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The University of Maryland Medical Alumni Association Bulletin is the official publication of the University of Maryland Medical Alumni Association and is published jointly four times annually by the University of Maryland Medical Alumni Association and the Faculty of the University of Maryland School of Medicine. Subscription price is \$5.00 per year in the United States, Canada and Mexico; and other countries \$6.00. Single copies, current and back copies, if available, are priced at \$2.00.

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Membership subscriptions (University of Maryland Medical Alumni Association) and business relating to membership should be sent to: University of Maryland Medical Alumni Association, University of Maryland School of Medicine, Room 201 Davidge Hall, 522 W. Lombard Street, Baltimore, Maryland 21201.

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# BULLETIN

university of maryland school of medicine

February, 1977

Vol. 62

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# The John Eager Howard Tower

## A Progressive Spirit . . . A Proud Tradition

Dianne T. Burch

More than a century and a half has passed since Colonel John Eager Howard first was associated with the University of Maryland School of Medicine. Land was bought from Col. Howard, Revolutionary War hero and former governor of the state, for the sum of \$10,000 of which he kindly donated \$1,000. On this land in 1812 was built "The Medical College" which later became known as Davidge Hall.

In the late 1950's, the medical school acquired and converted a former department store and warehouse at 660 West Redwood Street to a research and administrative facility and named it in honor of Col. Howard. Here were contained most of the preclinical instructional areas; however, the design did not allow the construction of adequate lecture facilities and in recent years the departments housed within became increasingly squeezed for space.

Additional space was sorely needed for sound reasons. First and most obvious, the student enrollment had been increased as part of the effort to train more physicians to meet the growing needs of the citizens of Maryland. The entering medical school class in the upcoming academic year will number 175 students compared to 137 just five years ago and 102 when Howard Hall was first opened.

Because of the lack of adequate contiguous areas, departmental space was often fragmented—

spreading out over several areas in one building, spanning several facilities or, at times, requiring supplemental off-campus sites. Sharing of resources and personnel was difficult, at best.

Curricular changes implemented in the past several years have necessitated the creation of numerous "small group" classrooms to accommodate the wide variety of elective offerings that forms an integral part of the first and second year curricula.

### Howard Hall Gains an Addition

This academic year marked the opening of a comprehensive teaching and research facility which bears its own entrance and address at 655 West Baltimore Street. Rising 14-stories above street level, and located just to the west of University Hospital the new addition to John Eager Howard Hall has become known on campus as John Eager Howard Tower or simply "Howard Tower". The School of Medicine gained more than 176,000 net assignable square feet of much-needed teaching, research, and administrative space. Howard Tower houses the freshman and sophomore lecture halls, small group classrooms, teaching and research laboratories in both clinical and basic science areas, faculty offices, conference rooms, and the administrative offices of the dean.

The decision to construct an addition as opposed



Looking south  
toward  
John Eager Howard  
Tower at night

to a separate structure was predicated largely on the ability to consolidate departmental space, particularly of the basic science departments which occupied old Howard Hall. In the new Howard Tower, floors 2 through 6 are essentially extensions of each department's former space thus allowing a contiguous space arrangement between the old and new facilities and eliminating the need to move an entire department.

To acquaint you with the general layout of the new facility, a floor directory is given below:

#### *Basement*

Anatomy  
Anatomical Board  
Physical Plant

#### *First Floor*

Lecture Halls/Classroom  
Student Council Office  
Student Lounge  
Study Carrels

#### *Mezzanine*

Office of Student Affairs  
Projection Booth

#### *Second Floor*

Anatomy  
Biochemistry

#### *Third Floor*

Microbiology  
Pathology

#### *Fourth Floor*

Pharmacology and Experimental Therapeutics

#### *Fifth Floor*

Physiology

#### *Sixth Floor*

Animal Quarters  
Rehabilitation Medicine

#### *Seventh Floor*

Anatomy

#### *Eighth Floor*

Medicine:  
Cardiology  
Endocrinology  
Gastroenterology  
Nephrology  
Nuclear Medicine  
Rheumatology

#### *Ninth Floor*

Baltimore Cancer Research Center

#### *Tenth Floor*

Neurology  
Pediatrics

#### *Eleventh Floor*

Anesthesiology  
Obstetrics and Gynecology  
Ophthalmology  
Pediatrics

#### *Twelfth Floor*

Neurology  
Psychiatry

#### *Thirteenth Floor*

Social and Preventive Medicine

#### *Fourteenth Floor*

Office of the Dean  
Office of the Senior Associate Dean  
Office of the Associate Dean, Governmental Liaison  
Office of the Associate Dean, Admissions  
Office of the Assistant Dean, Continuing Education  
Office of the Assistant Dean, Fiscal Affairs

### **Design**

The handsome, 14-story Howard Tower designed by Wheeler, Bonn, Schockey, Taylor, Inc., Architects complements other recent construction on the Baltimore campus and helps achieve a more cohesive sense of architectural unity within the sprawling urban campus. The general contractor for the building was Consolidated Engineering Company, Incorporated. The exterior of red brick with concrete trim work is balanced by large expanses of fixed tinted glass.

The building was designed in 20-ft. square modules with a central core for utilities on each floor. This concept allows for relatively easy modification of laboratory sizes if required in the future. All utilities are readily available in the core and can be extended to virtually any location in the building. A catwalk system rings the service core permitting easy access. The building is served by three passenger elevators and a freight elevator. Delivery of supplies and equipment is to an existing underground loading area located in the original Howard Hall.

The impressive, tinted glass entrance on Baltimore Street opens onto a spacious, slate-floored lobby. The use of natural materials is evident: exposed brick walls, massive concrete support columns,

stained woods. The back wall of the lobby and mezzanine walkway directly above are cast of concrete with a corrugated look. It is anticipated that this area will serve as a background for changing photograph and art exhibits by members of the campus community. Interior landscaping is being planned to "green up" the large lobby and soften the stark appearance. Thanks to the numerous windows on the north, east and south exposures, flourishing greenery in many of the labs and offices already contributes to the pleasant work environment.

To the right of the entrance is an open stairway to the mezzanine level. These two areas accommodate most of the student traffic each day since the lecture halls, student affairs office, bulletin boards, mail room, study carrels and other student-oriented spots are located there.

### **A Specialized Facility**

Howard Tower boasts an array of features that make it the most specialized facility on campus in terms of fixed equipment. The heating/cooling system permits individual, thermostatically-controlled rooms so that specified temperatures, of differing degrees, can be maintained in adjacent areas to meet varied research needs. Additionally, environmentally controlled rooms enable investigators to simulate specific nature conditions protected from ambient interference.

Shielded areas, known in jargon as "hot labs", have been built with special stringent safety features such as double-door entrances and exits, shower areas, autoclaves, and other precautions to protect workers within and prevent the leakage of hazardous substances, e.g., radio-isotopes and active viruses, to areas outside of the controlled lab. Many departments now are instituting or have plans to implement new or expanded studies because these sophisticated laboratories allow research that was in former less protected quarters too dangerous or impractical.

All of the building's laboratory spaces are equipped with the most up-to-date safety features. Overhead quick-pull showers and eye wash basins are noticeable along the lab corridors. In the event that an explosion or chemical spillage should occur, these devices are readily available to offset serious injury.

### **Improved Communications**

Dr. John M. Dennis, Vice Chancellor for Health Affairs and Dean, School of Medicine, expressed his pleasure with the new facility stating that it has done much to improve conditions in a number of areas. "The school is now more ready to meet the needs of the student body. Prior to the opening of Howard

Tower, we didn't have enough classroom space—the new building remedies this situation." He added, "The audio-visual facilities in the freshman and sophomore lecture halls are excellent." Dr. Dennis indicated that the new building has encouraged highly desirable interaction between the clinical and basic science departments.

From the departmental point of view, Dr. Dennis noted that the new Howard Tower has enabled many departments who were cramped to expand not only physically but into untried research areas as well. Those departments not assigned to or with insufficient space in Howard Tower should gain supplemental space when the second medical school teaching facility opens.

Perhaps most pleasing to Dr. Dennis is the fact that, for the first time, the administrative operation of the School of Medicine is consolidated. "This has done much to improve and strengthen communication between the Dean's Office and its administrative arms—admissions, continuing education, fiscal affairs, governmental liaison and student affairs. It's working beautifully."

The enthusiasm Dr. Dennis expressed for the communication improvement has been shared by many faculty members who have moved into Howard Tower. An often-voiced accolade has been the ability to communicate easily now not only with other members of a department but to share and exchange viewpoints with faculty members from other divisions or departments.

### **Student Life in Howard Tower**

As mentioned earlier, the first and mezzanine floors are probably the most active student areas in the building in terms of daily traffic. However, undergraduate, graduate and postgraduate students can be found in laboratories or classrooms throughout the new facility. Furthermore, potential students often get their introduction to life at the medical school at the admissions office on the 14th floor.

The two lecture halls, located on the first floor, are equipped with superior audio-visual equipment. The freshman lecture hall, which has a seating capacity of 360, features rear screen, video camera projection and the sophomore hall, 228 seats, has video monitors throughout as well. In both, standard front screen projection may be utilized. Dr. Murray Kappelman, Associate Dean for Student Affairs and Medical Education, noted, "The rear screen projection allows excellent visibility even for those seated in the back of the halls."

The location of media controls at the podium in both lecture halls assures the lecturer of full audio-visual coordination. Additionally, the Office of Medical Education has a media specialist on duty at all times.





Freshman Lecture Hall

Not only are the lecture halls used daily for classes, they are also scheduled regularly by clinical departments such as Family Practice, Pediatrics and Internal Medicine for grand rounds and continuing education.

The first floor also contains some "strictly student" areas—a student lounge and student council

Student Affairs Conference Room



office (both for the first time) and an audio-visual study carrel room. A small group classroom, used for the "Introduction to Clinical Practice" course, is also located there.

The Office of Student Affairs is conveniently located on the mezzanine level just beyond the interior balcony which overlooks the lobby. Dr. Kappelman stated that he and his staff were "very happy to be so close to the freshman and sophomore classrooms. The new office provides easy accessibility for the students." He added that the students who have visited the student affairs office have commented on the relaxing atmosphere. The assistant deans for student affairs now have private offices which contribute to the improved interaction with students. A comfortable conference room affords an ideal setting for student meetings and other departmental activities.

Because several departments occupy space on two or more floors, the simplest way to gain a look at what's going on inside Howard Tower seemed to be an alphabetical run-down of the many basic science and clinical departments and divisions. In some areas, space use is still in the preliminary stage awaiting the arrival of equipment, layout modifications, or additional personnel. Therefore the summaries which follow are intended to provide a brief survey of the multi-faceted facility and the scope of the research efforts contained within.

### Anatomy

As indicated in the floor directory, the Department of Anatomy under the chairmanship of Dr. Lloyd Guth occupies space on the basement, second and seventh floors.

The basement contains the embalming facilities of the Anatomical Board which is administered by the department for the state of Maryland. From this location, anatomical teaching material is supplied to

The spacious Anatomy Lab can accommodate 200 students.



the schools of medicine, dentistry and pharmacy; the VA hospitals in the state; and Johns Hopkins as well as the new Uniformed Services Medical School in Bethesda. Research laboratories in electron microscopy and autoradiography also are located in the basement.

One-half of the second floor is devoted to the study of gross anatomy. The spacious and bright gross anatomy area, overlooking West Baltimore Street, is equipped with 40 dissecting tables. With five students assigned to a table, the lab can accommodate up to 200 students at a session. Additional rooms are available for the study of x-ray anatomy, demonstration of prosections, and small group conferences.

The seventh floor contains the department's administrative offices as well as offices and research laboratories for three-fourths of the faculty. Research laboratories for neuromuscular physiology, histochemistry, tissue culture, and biochemistry can be found there. Research activities of several members of the department involve developmental biology and cytology. In cooperation with the Department of Pharmacology and Experimental Therapeutics, the department has recently established a paraplegia research laboratory.

### **Anesthesiology**

The department occupies space on the 11th floor in the form of two offices and two laboratories. Basic anesthesia research in the areas of pharmacology and physiology will be explored according to Mr. Richard Wilby, department administrator. Until this additional research space was assigned, investigations had been confined to clinical studies in the department's other research unit housed in the Bressler Building.

### **Animal Quarters**

According to Dr. Kveta Vitek, director, the expansion of existing space on the sixth floor of Howard Hall to the new space in the addition is most welcome. Dr. Vitek expressed her pleasure with the supplemental space which has a number of desirable features. Surgical facilities, previously unavailable, will now be provided for use by investigators in any department who require surgery in their experimentations. A prime advantage is that such surgical procedures will now be conducted in an area that assures aseptic conditions.

The animal quarters are divided into a number of controlled environment areas so that investigators can establish and maintain the ideal climatic conditions for each type of animal.

The dog space, which has proved to be inadequate in old Howard Hall, will now be equipped with kennel pens, each with automatic watering

devices. Additionally, the area has industrial-type washers that permit the thorough cleaning of cages and other equipment. A negative suction system prevents odors from escaping to other sections of the floor or building.

### **Baltimore Cancer Research Center**

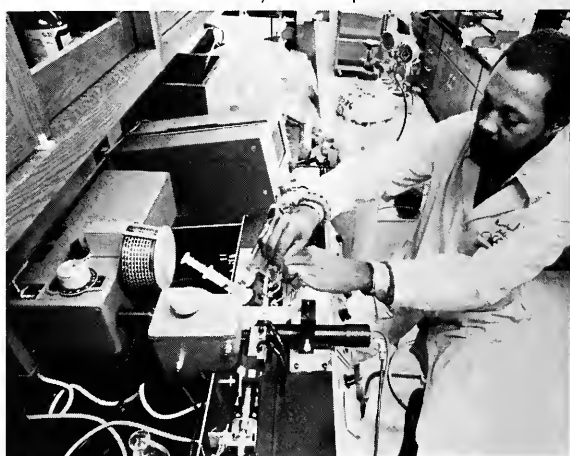
Hopefully in spring, the laboratory component of the Baltimore Cancer Research Center will move its operation from the U.S. Public Health Service Hospital at Wyman Park to the ninth floor of the Howard Tower. Dr. Michael Walker, director, noted that some modifications must be made to the floor before equipment vital to the center's research operation can be moved in place. Plans also call for a covered walkway to be constructed between the ninth floor of the hospital and the ninth floor of the addition, providing a vital link in the establishment of close communication between the clinical and laboratory wings. "It's somewhat unusual for M.D.'s and Ph.D.'s to work closely together—but such cooperation is essential if we are going to succeed in the fight against cancer," emphasized Dr. Walker. "At present," he continued, "with one foot [clinical] at University and the other [research laboratories] at USPHSH, such cooperation is difficult."

Research into the pharmacology, immunology and enzymology of the disease will be conducted in the Howard Tower space. When complete, the BCRC will have research, inpatient and outpatient facilities in one continuous space enabling investigators to study cancer from the "whole patient" to the molecular level.

### **Biochemistry**

The Department of Biochemistry has expanded its space from the second floor of old Howard Hall into adjoining space on the second floor of the Tower. According to Dr. Barry Rosen, associate professor, the new space (approximately half of the second

Biochemistry's new stop-flow instrument



floor) will be used for a continuation of existing research. Three research groups are housed in the new facility.

Dr. Rosen's group is studying bacterial membranes and bioenergetics. Dr. Lindsay Black, associate professor, is looking into the morphogenesis of the bacteriophage T<sup>4</sup>. Enzymology is the focus of research conducted by Dr. Mary Kirtley, professor, and her staff. In addition, the department has five smaller laboratories. Several postdoctoral fellows as well as a number of graduate medical students are working in the new facility.

New equipment purchases for the department include an electron microscope, an ORD-CD machine which measures the properties of molecules in solution, and a stop-flow instrument used to study kinetics of rapid reactions to determine mechanisms of action in certain enzymes. Dr. Rosen noted that the ORD-CD machine is unique to the biochemistry department.

**Medicine**

As shown in the floor directory, the Department of Medicine chaired by Dr. Theodore Woodward has gained research space for six of its divisions on the eighth floor: cardiology, endocrinology, gastroenterology, nephrology, nuclear medicine and rheumatology.

Dr. Alfonso Janoski, assistant professor in the division of endocrinology, is using division space to continue research in adrenal physiology. Current funding is in the form of an NIH grant for support of \$162,000 for the next three years. Dr. Janoski is very pleased with the proposed animal quarters since his research involves the use of monkeys in the study of ovarian physiology and the use of rats in a hypertension study.

He commented, as others have, upon what he believes to be an important aspect of the new facility, that is, the closer interaction between clinical and basic sciences. He also pointed out that the space layout in the building has allowed divisions of medicine to share expensive equipment.

The division of gastroenterology directed by Dr. Frank L. Iber has five laboratories and an office. The main focus of the division's research has been liver disease in alcoholics. However, the division is now branching out into studies of asymptomatic hepatic carriers, gallstones, and a new technique of breath analysis to assess liver malfunction. Five senior staff members, seven fellows and numerous technicians have offices and labs in the new space. Approximately four medical students will rotate through the department in Howard Tower each year.

Biochemical and physiological studies of dialysis patients are the research objectives of the division of nephrology which has four labs and an office. This research focus was instituted by Dr. John R. Little, associate professor. Nephrology fellows, there are four at present, spend a portion of their time conducting research in the laboratories.

Two laboratories have been assigned to the division of nuclear medicine for research purposes. The division is involved in five avenues of research: neuropharmaceuticals, bacterial identification, polyp studies in collaboration with the dental school, pulmonary research, and vascular surgery. Plans call for the extension of present interdisciplinary research with the schools of pharmacy and dentistry.

**Microbiology**

Dr. William F. Myers, assistant professor in the department, views the expansion into the third floor

Microbiology area



of Howard Tower as a significant step in that it will enable the department to explore research areas previously untouched. The department's new space contains one of the "hot labs" mentioned earlier. "In the past," he explained, "the department has had to shy away from research that involved dangerous bacterial or viral agents because such a facility was lacking."

Other features built into the department's acquired space are the environmental cold rooms. One is designed primarily as a storage facility and the other as a working laboratory which assures the purification of biological products that would be damaged if exposed to warmth. The department also has its own animal facilities with a number of desirable features such as double air lock doors, negative air pressure, and industrial-type cleaning equipment.

Several specialized instrument rooms are also available to all members of the department. Equipment includes a cell fractionator which breaks open bacterial cells by means of a forceful hydraulic press. Beta and gamma scintillation-type spectrometers provide accurate and automatic large-scale samplings which are recorded by a computer print-out. Such equipment is essential to the department's continuing emphasis on rickettsial studies.

### **Neurology**

The Department of Neurology has three research groups assigned to the new facility: Dr. Erland Nelson, professor and chairman; Dr. Richard F. Mayer, professor; and Dr. Stephen Max, associate professor. Dr. Nelson is conducting research on stroke and cerebral blood vessels. Dr. Mayer is involved in neuromuscular research while Dr. Max is engaged in muscle disease studies. Space for the department is on both the 10th and 12th floors.

### **Obstetrics and Gynecology**

Exemplary of interdepartmental cooperation is the "space use committee" for the 11th floor departments. Dr. Isadore G. Ances, professor of obstetrics and gynecology, was instrumental in establishing this committee. Joint-use purchases have included a Wang computer, a liquid scintillation counter, and a spectrophotometer.

Both ongoing and new research endeavors are being conducted in Howard Tower. Ongoing studies include tissue culture, steroid and peptide analysis, and chromosome research. Prenatal diagnosis and tissue culture of germ cell tumors are two new areas being explored.

### **Ophthalmology**

Dr. Shambhu Varma joined the Department of Ophthalmology in late October to assume the post

of director of the research laboratory. Dr. Varma was the first to discover a cure for diabetic cataracts in animals through the use of flavonoids (vitamin P). The next phase of his research will be the determination of the stability of such a technique to see if these findings can benefit human diabetics.

Ophthalmology has three labs dedicated to research of the eye and is located on the 11th floor. An electron microscope facility and a spectrophotometer, available for the department's use, are invaluable new pieces of equipment.

Dr. Varma's research group is furthering research which he initiated prior to his arrival at the University of Maryland by studying the effect of diabetes as a mechanism causing the formation of cataracts. Also being studied is the effect of sunlight on the lens.

Dr. Richard D. Richards, professor and chairman, is looking into the x-ray as a possible cause of cataracts. He also is involved in the effect of aging on the lens to develop a better understanding of why the lens becomes semi-transparent as a person grows older, thus reducing visual capabilities.

### **Pathology**

The Department of Pathology is utilizing the space they acquired on the third floor of Howard Tower for an expanded and centralized electron microscope facility housing laboratories, darkrooms and EM prep rooms. This central service facility can be used by members of the pathology department, as needed.

### **Pediatrics**

In discussing the department's space allocation on the 10th and 11th floors, Dr. Tyson Tildon, professor and director of pediatric research, and his colleague Dr. Pinar T. Ozand, professor, expressed pleasure with their new surroundings. Prior to the opening of Howard Tower, the research component of the department was scattered around campus and off-campus at Rosewood State Hospital. Research groups, involved in as many as 20 varied projects, are now able to interact with one another. The department believes very strongly in the team approach to problem solving and the new facility has enabled such cooperation to become a reality thanks to the close proximity of faculty working in a number of vital areas. Additionally, Dr. Tildon observed that the department's goals of public health service, research, and education have been strengthened.

The department is most grateful to have been granted new equipment. The Beta and gamma scintillation counters and the double-beam spec-

trophotometer and autoanalyzer have increased the department's research and productivity capabilities. For example, what used to be a five-day procedure has been shortened to a one-day turn-around time since the department acquired the automated counters. Before, large-scale sampling was an impossibility due to the lack of such equipment.

Topics of research being conducted in the Howard Tower space, which is filled, include the study of newborn metabolism and developmental biochemistry. Also, the study of diabetes in pediatric patients is being looked at from a variety of viewpoints—that of the immunologist, the endocrinologist, and the biochemist. A major new project is research into the sudden infant death syndrome.

Ongoing research into inborn errors of metabolism, i.e., genetic disease, is being conducted with a new approach. Skin biopsies are being examined in the new tissue culture facilities.

Research on the 11th floor entails pediatric endocrinology and studies of psychiatric development in early childhood in conjunction with the Department of Psychiatry.

### **Pharmacology and Experimental Therapeutics**

Dr. Edson X. Albuquerque, professor and chairman of the department, has expanded his space into the 4th floor of Howard Tower. With this acquisition, part of the previous laboratory space will be converted to classroom and conference room facilities, sorely needed by the department.

Within the new facility, five areas of research will be probed. These are: 1) synoptic noise in mammalian tissue, 2) myasthenic muscle study of myasthenia gravis, 3) hibernation studies, 4) spinal cord regeneration (in conjunction with the Department of Anatomy) and 5) immunological studies in myasthenia gravis utilizing both animal and patient models.

Special features of the department include an advanced tissue culture laboratory and a new electron microscope facility which Dr. Albuquerque termed "excellent."

At present, the department is being funded by National Institutes of Health for the studies of neurological disease and paraplegia. The department was also awarded a grant from the Muscular Dystrophy Association to continue its research.

In addition to the faculty, seven post-doctoral students from a number of countries are engaged in research in the Howard Hall addition.

### **Physiology**

The Department of Physiology now occupies the entire 5th floor of Howard Tower as well as the former space on the same floor in old Howard Hall.

The new space allows for a series of laboratories, the administrative offices of the department, seminar room, library, graduate student offices, and ancillary support facilities.

Research housed within Howard Tower falls into four general categories: 1) reproductive endocrinology, supported by NIH research and training grants, by Dr. Charles A. Barraclough, professor, and Dr. Cornelia Channing, professor; 2) renal transport by Dr. Gabriel G. Pinter, professor; 3) neurophysiological studies of balance and motion by Dr. Charles Abzug, assistant professor; and 4) exploration of ion transport in nerve and muscle by Dr. F. J. Brinley, professor, and Dr. Lyle Horn, assistant professor. The latter research thrust is new to the department having been introduced by Dr. Brinley who recently joined the staff.

In addition to faculty research, the area is utilized for the training of graduate students, approximately six, and postgraduate fellows of which there are ten at present.

### **Psychiatry**

One half of the 12th floor is devoted to research space for the Department of Psychiatry and is divided into two basic endeavors: neurobiological studies and psychosomatic research. A spacious classroom provides a facility for case conferences and teaching space for medical students and residents. The department also has shielded chemistry labs in which Dr. Russell Monroe, professor and chairman, plans to explore further the biochemistry of psychosomatic disorders.

Psychosomatic research entails the testing of new approaches to clinical treatment of psychophysiological diseases such as insomnia, migraine headaches, hypertension, and neuromuscular disorders at the human level. As Dr. James Lynch, professor and scientific director of the psychosomatic clinic, explained, "Research is being conducted to study how the environment interacts with the body to cause changes in both normal and abnormal ways." To this end, psycho-physiological research methods are employed and new techniques are explored. The area features "shielded rooms" which a subject can enter and gain help by biofeedback techniques for disorders such as migraine headaches.

Dr. Lynch added that such an effort "is probably one of the most interdisciplinary since research into psychosomatic illness crosses so many disciplines." Other faculty members involved in research in the new facility include: Dr. Thurmon Mott, Jr., director of student health, who is involved in hypnosis techniques; Dr. Virginia Huffer, head of liaison psychiatry and medical director of the psychosomatic clinic; Dr. David Paskewitz, a psycho-

physiologist and assistant professor, who is an expert in sleep and sleep disorders.

### Rehabilitation Medicine

Dr. Paul Richardson, professor and chairman, explained that his department is somewhat of a neophyte in that for the first time research space has been assigned them. The department is recruiting actively for additional members to do research in the clinical application of electrophysiology in neuromuscular disease and to develop further an orthotics lab. At present, a volunteer orthotist is helping set up such a facility and the appropriate guidelines for the recruitment of a director.

### Social and Preventive Medicine

The Department of Social and Preventive Medicine now is able to have all of its principal investigators in one location as a result of its move to the 13th floor. The department is most pleased that, at last, it has adequate office space. Most of the department's research, by its nature, is conducted in the field. However, two studies are based in the new space. One is a nutrition study and the other is a study by Dr. Charlotte Ferencz, professor and acting chairman, on maternal hormone therapy and congenital heart disease.

Twelve study carrels, located in the department, are used by students participating in the extensive summer apprentice program, a large component of the department with a two-fold purpose: 1) to introduce students in greater depth to components of social and preventive medicine and 2) to encourage independent research among those students with established interests. Generally, freshman and sophomore students participate in periods of from 10-12 weeks.

The sophomore course, "Quantitative Medicine and Clinical Epidemiology," is taught in the 13th floor classroom to those students who choose the "small group" format which is a more specialized study with an epidemiological focus.

### Administration

The top and 14th floor of Howard Tower is shared by the Dean's Office personnel and support staff. This floor houses the Dean's suite for Dr. Dennis, Dr. Morton I. Rapoport, Senior Associate Dean, secretarial staff and conference room. Also located on the south side of the floor is the Office for Fiscal Affairs, headed by Mr. Gregory Handlir, Assistant Dean.

The north corridor houses three administrative components: the Program of Continuing Education under the leadership of Dr. William Jessee, recently appointed Assistant Dean for Continuing Education; the Admissions office under the direction of Dr. Willard Allen, Associate Dean; and the Office of Governmental Liaison, directed by Dr. Frederick J. Ramsay, Associate Dean.

A conference room on this floor is being designated as a resource facility and library which will house recent publications acquired by the governmental liaison office as well as other departments such as continuing education. These publications will be available for loan to interested faculty.

### The Outlook

The University of Maryland School of Medicine continues to grow dynamically not only physically but effectively. With research support having increased over the past five years in spite of federal regulatory controls and the class size having expanded by more than 30 students during that same period, the continuation of our physical expansion is axiomatic. The School looks forward to the future with enthusiasm and the full expectation that it will meet the challenges of the 1980's as a leader in health care education, service and research.

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Ed. Note: Dianne T. Burch is Assistant to the Dean for Publications, University of Maryland School of Medicine. Photos by Phil Szczepanski.

#### PHYSICIAN

Full-time position available with twelve man multi-specialty group practice located in Eastern Baltimore County. The existing five-man Medical Department is searching for a General Practice or Family Practice physician licensed in Maryland. Partnership position is available. Excellent benefit program and salary commensurate with experience. Send curriculum vitae to: P. Piasecki, 1107 North Point Blvd., Suite 203, Baltimore, Md. 21224.

#### PHYSICIAN

Part-time position available for General Practice or Family Practice physician. Twelve man multi-specialty group practice located in Eastern Baltimore County. Afternoon, evening and Saturday morning hours available. Need coverage 18 hrs./week minimum. Send curriculum vitae to: P. Piasecki, 1107 North Point Blvd., Suite 203, Baltimore, Md. 21224.

# Continuing Education: Are You Satisfied?\*

William F. Jessee, M.D.

Are you satisfied that your continuing education efforts are paying off? The majority of practitioners in a recent study in Michigan<sup>1</sup> said they were not. Unhappily, there is no easy way to correct the situation. There is, however, a systematic way to deal with this problem—devise a plan for continuing education that fits your particular needs, interests, and concerns.

The rewards of a systematic approach are four-fold:

First, you'll know how well you're growing in knowledge and skill. Consequently, you can control that growth in directions you think desirable to more effectively meet the needs of your patients.

Second, you'll improve your medical competence in ways directly related to the particular configuration of your practice.

Third, the 200 or more hours you devote each year to continuing education will be spent in the most efficient manner possible, with consequent greater return for this investment of your energy and time.

Fourth, you'll easily satisfy CME requirements of medical organizations and institutions and of governmental agencies.

Granted the rewards, you may still think, "Developing a systematic plan will take time. Wouldn't I be better off using that time on my reading or attending a CME course? There's a plethora of CME available; if I just pick out the things that interest me, won't I be learning most effectively?"

Perhaps you will, but you'll never know because you won't be controlling your professional growth. Central to this consideration is an important fact about contemporary CME that deserves emphasis: its discontinuity. One scholar describes the situation so:

The journal, the annual convention, or the regularly scheduled meeting provide as much continuity as is thought necessary, and even in such cases it is only the method of presentation which is continuous, not the messages brought.

Other forms of continuing education usually make up an amalgam of bits and pieces of expe-

rience. The content of each activity is based on whatever is, for the moment, new, usually some specific area of knowledge or technique which lies at one of the frontiers of rapidly expanding knowledge or practice. The professional learns one element of novelty; later on, perhaps, he learns another, but the second is not designed to be linked to the first in any meaningful way. The growth of knowledge, the refinement of skills, and the deepening of understanding or of ethical sensitivity are achieved, if at all, by what appears to the outsider to be a zigzag and erratic course<sup>2</sup>.

Put another way: In college, medical school, internship and/or residency, somebody prescribed a more-or-less integrated set of learning experiences that led you systematically to mastery of medical knowledge and skills. In the process, you had frequent opportunity for evaluation of learning achieved—a crucial element in your progress. Now, you're on your own: If you don't plan your continuing education, it'll be haphazard and perhaps even counterproductive.

## The Elements of a Good Plan

### *Seven Steps to CME Success.*

To prepare a good plan, there are seven essential steps:

1. *Determine Your Needs.*
2. *Assess Your Practice.*
3. *Select Specific Learning Objectives on the Basis of the First Two Steps.*
4. *Decide How to Achieve Each Learning Objective.*
5. *Inventory Learning Resources Available to You.*
6. *Decide on Priorities and Establish a Schedule.*
7. *Evaluate Your Learning Achievement.*

To use these steps wisely, you'll probably be better off to set up a rather small plan. When you start thinking about your NEEDS—i.e., areas of medicine in which you do not feel fully competent, and compare them with the kind of patients you're seeing, you can easily select a dozen or more areas. CUT THEM DOWN TO ONE. For example, analysis of your practice may reveal a growing number of skin rashes among your patients, which you feel are not being dealt with as well as possible. In that case, you might choose two or three learning objectives

\*This article is based on a booklet entitled, "Your Personal Learning Plan: A Handbook for Physicians," by Leonard S. Stein, Ph.D., published by The Illinois Council on Continuing Medical Education, Chicago.

(Step Three) in the area of allergy. When you've worked through all seven steps and evaluated this first piece of learning, your second plan might well be larger in scope.

### Preparation

Once you decide that it's worth the time required to develop a personal learning plan, you'll find these few preparations helpful:

1. Set up a "*Learning File*"—preferably the top drawer in a file cabinet next to your desk. Have your secretary set up three sections:

a) General: One folder labeled "Ideas," plus a folder for each of the seven steps involved in developing your Plan.

b) Sources of CME: A folder for each learning source you decide is important—the University of Maryland, medical schools, specialty societies, and other organizations.

c) Learning Material: A folder on each subject area or topic that interests you.

2. Set aside a *Definite Schedule* for the development of your personal learning plan. Two to three hours a week is likely to be optimal. DO NOT work through the entire plan in one sitting; rather, take it step-by-step, over a period of some weeks or even months. DO NOT feel that you must complete the entire plan before continuing your regular learning activities. Depending on your personality and work-habits, you might find it best to work through Steps One, Two, and Three with some speed and then take a longer period on Steps Four and Five. How long you spend on learning activities and on Step Seven depends on your decisions in the first five Steps.

### Look Ahead

When you've completed your personal learning

plan, set it aside with a "flag" for your secretary to remind you to look at it again, six months or so later. A good personal learning plan is one that grows along with you. Once you've completed one set of planned learning experiences, you'll find yourself eager to plan the next set—to bring your personal learning plan up to-date. So start over again working through steps one through seven (and the second plan will take less time to complete than the first). You're likely to find yourself developing two, or three, or even five or six learning plans. SAVE EACH ONE; reviewing old ones will give you the crucial personal satisfaction of being able to see, directly and personally, how much growth you've enjoyed.

Over the next several issues of the *Bulletin*, we hope to address in greater detail each of the steps in developing a personal learning plan. We hope that this will be of value to you in selecting your CME choices. If you identify CME needs to which the University can respond, please let us know. The Program of Continuing Education exists to serve you and depends upon your continued support.

### References

<sup>1</sup> Floyd C. Mann et al., "The Michigan Physician and His Continuing Education," *Michigan Medicine*, Vol. 69, No. 21 (November, 1970); and "The Michigan Physician: His Work Needs and Opportunities," loc. cit., Vol. 69, No. 23 (December, 1970).

<sup>2</sup> Cyril O. Houle, "To Learn the Future," *Medical Clinics of North America*, Vol. 54, No. 1 (January, 1970), pp. 5-17.

Ed. Note: Dr. William F. Jessee is Assistant Dean for Continuing Medical Education, University of Maryland School of Medicine.

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## The Herbert Berger Lecture Established

Herbert Berger, M.D., Class of 1932, of Staten Island, New York, has kindly donated funds to the University of Maryland School of Medicine for an annual lectureship in Internal Medicine to be titled: "The Herbert Berger Lecture."

Dr. Berger states, "This gift is in return for not only my medical education which has given me a fascinating life but particularly for the Karlinsky

Scholarship which I won in 1929."

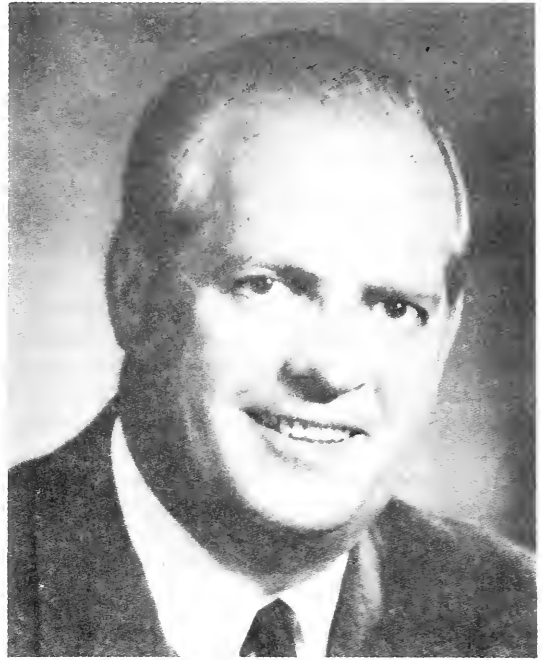
Dr. Berger is presently Professor of Medicine at New York Medical College and Director Emeritus of Medicine at Richmond Memorial Hospital.

The Board of Directors of the Medical Alumni Association and the University of Maryland School of Medicine gratefully acknowledge Dr. Berger's meaningful contribution to medical education.



## Dean's Message

*John M. Dennis, M.D.*



The Office of the Dean and the other administrative offices have been consolidated on the fourteenth floor of the new Tower Addition to John Eager Howard Hall. Previously, the administrative units were scattered in several locations on the campus, making communication very difficult. I did not wish to move my office from Davidge Hall, but the necessity to bring all the administrative units together in one area outweighed my desire to remain in Davidge Hall. The new suite of offices, however, does have a beautiful commanding view of the city and I hope that all of you will take the opportunity to visit.

This year's entering class has 175 students of whom 38 are women and twelve are minority students. We are making an effort to admit as many as possible new students with legacies, and the present class has 17 sons and daughters of alumni with offers having been made to 25. Of course, those students with legacies must be competitive academically.

In addition to the 175 students in the first-year class, we also transferred 11 students from foreign medical schools into the third-year class. There was an equal number of Maryland residents who were qualified for transfer on the basis of grades and passing Part I of the Examination of the National Board of Medical Examiners, but we could not accommodate these students because of faculty size and facilities.

I want to thank all of those alumni and friends who have contributed financially to the School of Medicine this year. The annual giving this year amounted to just over \$30,000 as of December 21, 1976, though I am confident there will be more contributions by December 31, 1976. The Medical School Foundation, which I reported on during the past year, is being developed in conjunction with the Alumni Association, and contact should be made with each of you in the near future. Annual giving has become important in all schools as state, federal and private foundation support has not kept pace with program growth and inflation.

# Bicentennial Celebration

The bicentennial celebration of the School of Medicine held on December 6, 1976 began in a most fitting manner with a convocation in Davidge Hall. After opening remarks by Dr. B. Herbert Brown, Chairman of the Board of Regents, Dr. Wilson B. Elkins, President of the University, and Dr. James A. Roberts, President of our Alumni Association and selections by the University Choral Groups to set the historic mood of the afternoon, the Honorable Rogers C. B. Morton in the 20th Maurice C. Pincoffs' Lecture told how a politician views the problems of medicine and the delivery and costs of

medical care. President Elkins then conferred the honorary degree of Doctor of Public Service upon Mr. Morton.

Short memorable vignettes of Maryland's medical history were given by the Honorable Louis L. Goldstein, Comptroller of the State of Maryland, Dr. Thomas B. Turner, Class of 1925, and Mr. Walter Lord, author. A formal dinner and musicale rounded out the day's activities.

On Tuesday following, both scientific and social activities sponsored by the professional associations of the University of Maryland Hospital—the University of Maryland Hospital Surgical and Medical Associations and the Bradley Pediatric Society—were well attended and many alumni came to participate. The *Bulletin* hopes to feature some of the presentations from these conferences and meetings in future issues.



The Honorable Rogers C. B. Morton delivered The Twentieth Maurice C. Pincoffs Lecture.



Dr. Mario R. Garcia-Palmieri lectured on "The Spectrum of Cardiac Disorders in Puerto Rico."



Walter Lord, distinguished author, spoke on "How Lack of Medical Knowledge Once Saved Baltimore."

Seated left to right: Dr. Wilson H. Elkins, Mr. Walter Lord, Dr. Thomas B. Turner. Standing: Members of the Combined University Choral Groups.



Dr. Roger Michael gave the tape/slide presentation on Davidge Hall.

# Anesthesiology in Maryland: The Community and The University\*

Otto C. Phillips, M.D.

You might ask why I, living in another community and never having been a member of the full time faculty at the School of Medicine of the University of Maryland—why I should be asked to give a talk on the history of anesthesia in the school and in the community. The answer is simple. Recently, one of our trainees in anesthesia asked another member of the staff if we had a book in our library on the history of anesthesia. My colleague replied: "That isn't necessary. Just ask Dr. Phillips, he was there!" That wasn't quite true; I must admit that, at the very beginning, I was not on the scene of action.

We are all aware that the predecessor of the surgeon was the barber. The witch doctor was the forerunner of the internist. However, we read in Genesis, Chapter 2, Verse 21 that "The Lord God caused a deep sleep to fall upon Adam, and he slept: and He took one of his ribs, and closed up the flesh thereof." This state was induced for the birth of Eve, so that Adam would feel no pain. Thus, the prototype of the anesthesiologist was none other than the Lord himself, who administered the first recorded anesthesia.

Despite His compassion toward Adam, and Betty Friedan and Gloria Steinem notwithstanding, if we read further, we get some insight into the Lord's sentiments regarding Women's Lib—and Eve's travail in specific. In Genesis, Chapter 3, Verse 16 He spoke as follows: "I will greatly multiply your pain in childbearing; in pain you shall bring forth children." In time, and with His forbearance and guidance, this philosophy has been tempered, and we are now offering some means of relief from the pain of childbirth. We might note further, however, that in

recent years the pendulum has swung back and there is a resurgence of interest in "natural childbirth". Throughout history and in all societies, delivery has been, and still is, associated with discomfort. This therefore denotes normalcy; as it was in the beginning, the natural way is with pain.

We shall now skip a few years. Our discussion of highlights in the development of anesthesia at the University of Maryland and in the community will begin with the introduction of the twentieth century. At that time, one physician in Baltimore, Dr. S. Griffith Davis, was devoting full time and attention to the practice of anesthesia; he worked with surgeons in both of the universities and in most, if not all, of the hospitals. We were destined to hear more of him later.

The first original recorded contribution to the anesthetic care of patients in this community was made in 1903 by Harvey Cushing,<sup>1</sup> a neurosurgeon at the Johns Hopkins Hospital. While visiting in Italy, a colleague of Riva-Rocci gave him an inflatable armlet and manometer; Dr. Cushing believed that these would be more reliable for documenting the condition of the patient than the palpating finger of the anesthetist. He faced familiar objections, of course, such as: "Are we not surfeited with instruments of accuracy in clinical work?"; and, "Are not approximate values in the long run as useful as precise ones?" Nonetheless, he persisted and introduced into operating room records a graphic chart of the progress of blood pressure during the course of anesthesia.

Two years later, in 1907, "Griff" Davis wrote the first article by an anesthesiologist in Baltimore; this was about "The Administration of Ether By The Drop Method."<sup>2</sup> Incidentally, and totally unrelated, of course, this happened to be the same year that the Annual Register in London surprised us by writing of our folk-hero, Teddy Roosevelt, that "... his favorite amusements are preaching and slaying", and that "Next to making speeches and urging his fellow-countrymen to live righteously his keenest enjoyment is to be found in killing something."<sup>3</sup>

In 1913, Dr. Davis was appointed instructor in anesthesia at the School of Medicine of the University of Maryland, the first faculty appointment in this field. Four years later, in 1917, he developed with Dr. S. J. Crowe the Davis-Crowe gag for maintaining an airway during tonsillectomy. Modifications of this instrument are still in use in most hospitals in the country.<sup>4</sup> Among other historic events of that year,

\* Delivered at the Bicentennial Celebration, The University of Maryland School of Medicine, December 7, 1976.

The editor hopes to publish other presentations from the Bicentennial Celebration for those who were unable to attend.

<sup>1</sup> Cushing, H.: On routine determinations of arterial tension in operating room and clinic. *Boston Med. Surg. J.* 148: 250-256, 1903.

<sup>2</sup> Davis, S.G.: The administration of ether by the drop method. *Md. State Med. J.* 50: 171-174, 1907.

<sup>3</sup> Low, M.A.: "The United States of America," *The Annual Register: 1907*. London: Longmans, Green, & Co., p. 441, 1908.

<sup>4</sup> Crowe, S.J., Watkins, S.S., Rothholz, A.S.: Relation of tonsillar and nasopharyngeal infections to general systemic disorders. *Bulletin of The Johns Hopkins Hospital* 28: 1-63, 1917.

war was declared against Germany. And in that same year, incidentally, your speaker was born—and given the name, Otto, to boot! Two years later, in 1919, Mencken's "The American Language" was published.

In 1920, Dr. Davis was appointed Professor of Anesthesia; he held that office until the time of his death in 1943. It was during this latter year that his namesake, Elmer Davis, Office of War Information, was criticized for stating that "a free people has a right to know . . ."<sup>5</sup> At this time, also: General George Patton was chasing Rommel in the sands of North Africa and later summed up his philosophy: "It makes no difference what part of Europe you kill Germans in";<sup>6</sup> the cover of Time magazine noted of Bernard Baruch, "His eyes have seen the panics and follies of two wars";<sup>7</sup> and pin-up girl Betty Grable married schmaltz jazz trumpeter, Harry James.

This was a period in many schools when academic appointments were coincidental to other activities, and, of necessity, consumed little of the appointee's time. In 1936, Morris Nicholson, a native of Maryland and a former All-American lacrosse player, was an intern at the University Hospital. While rotating through gynecology, he spent alternate days scrubbing and giving anesthesia. He was instructed in open drop ether by a nurse, Miss O'Brien, who advised him, "Listen to them breathe." He considered this one of his most valuable lessons in anesthesia. This happened also to be the year that love conquered all. Edward VIII abdicated the throne of England in favor of the hand of the Baltimorian, Wally Simpson.

Dr. Nicholson was relieved early from his internship rotation to go to the Lahey Clinic in Boston for more formal training in anesthesia, with the understanding that he would come back and join the anesthesia "team". He did so, and, though his tenure was quite shortlived, "Nick" was the first physician to spend full time as a member of the anesthesia staff at the institution. His major contribution was to persuade the administrator to buy two anesthesia machines, so that the total department at the time consisted of two machines, two nurses, and himself. After trying unsuccessfully for two whole weeks to get some commitment as to his role at the

hospital and for longterm plans for the development of a department, he returned to the Lahey Clinic, where he has remained ever since.

At just about this time, your speaker applied for admission to the School of Medicine at the University of Maryland. He was a bit uneasy and even disappointed at his first personal contact with the school. His interviews relating to this important matter were in the hands of two youthful men, who to him seemed hardly to have accumulated the necessary years to be medical graduates themselves. One of the faculty happened to be Dr. Frank Figge, who, in a few years, became Chairman of the Department of Anatomy. The other was Dr. John Krantz, Professor of Pharmacology, destined to become an eminent investigator in the field of anesthesia.

In 1943, Dr. Austin Lamont was appointed chief of anesthesia at Hopkins, the first such university position in the city. He remained at this post until 1946, when he moved to Philadelphia, and the department was without a head for a number of years.

Dr. Fred Dye, another graduate of the residency program at the Lahey Clinic, at first joined the Army, where he was "discovered" by some of the surgeons with the University unit. He came back to Baltimore in 1946 to head the anesthesia department at the University Hospital. At this time, the 65 year old "Sage of Baltimore", H. L. Mencken, was commenting that World War II was covered wordily but not well—"I don't even know yet what generals got licked";<sup>8</sup> one of these generals, George Marshall, was advising that "We must not waste the victory";<sup>9</sup> Time magazine was observing of labor leader, John L. Lewis, "O, it is excellent to have a giant's strength, but it is tyrannous to use it like a giant . . .";<sup>10</sup> and Frank Leahy, football coach at Notre Dame, was admitting that "Prayers work better when the players are big."<sup>11</sup>

Dr. Dye left in 1948 and was succeeded by Dr. Alfred Nelson, a University of Maryland alumnus and a former resident at the University Hospital. Dr. Robert Dodd was another product of the Boston training camp, but at the Massachusetts General Hospital. He followed Dr. Nelson in 1952 and left in 1956, at which time Dr. Paul Hackett remained as acting head of the department.

In 1953, Dr. John Krantz published a paper on "The Anesthetic Action of Trifluoroethyl Vinyl Ether."<sup>12</sup> This work was significant in two ways. It was the first of a series of papers on the volatile fluorinated hydrocarbon inhalation agents. It also introduced a new era in the pharmacology of volatile anesthetics; it was the beginning of the methodical and systematic approach to correlating chemical structure with physiological responses to the drugs.

At this time, Dr. Max Sadove, a former student, was Professor of Anesthesia at the University of Il-

<sup>5</sup> Time (cover), Vol. 41, March 15, 1943.

<sup>6</sup> Time (cover), Vol. 42, July 26, 1943.

<sup>7</sup> Time (cover), Vol. 41, June 28, 1943.

<sup>8</sup> Time, Vol. 47, p. 70, January 14, 1946.

<sup>9</sup> Time (cover), Vol. 47, March 25, 1946.

<sup>10</sup> Time, Vol. 47, p. 15, May 20, 1946.

<sup>11</sup> Time, Vol. 48, p. 63, October 14, 1946.

<sup>12</sup> Krantz, J.C., Carr, C.J., Lu, G., Bell, F.K.: The anesthetic action of trifluoroethyl vinyl ether. J. Pharmacol. Exp. Ther. 108: 488-495, 1953.

linois. Dr. Krantz wanted to be the first human subject anesthetized with the new drug, with Dr. Sadove administering the anesthesia. Max declined and suggested that the tables be reversed—so the Professor of Pharmacology anesthetized the Professor of Anesthesia. Both parties survived.

In the next year, 1954, your speaker proposed that a community anesthesia study committee be established. This concept was endorsed by the Baltimore City Medical Society and the Baltimore City Health Department, and it led to an ongoing review of postoperative, postanesthetic deaths in the city.<sup>13</sup> A statistical analysis of 1,024 of these cases, published in 1960, is now recognized as one of the most meaningful reviews of anesthesia mortality in the medical literature.<sup>14</sup>

During the years 1957 and 1958, important contributions were made in the field of cardio-respiratory physiology, which, along with anesthesia, is one of the areas of particular interest and expertise for the anesthesiologist. Dr. Kouwenhoven, an engineer at Hopkins, demonstrated a technique for closed chest defibrillation of the heart;<sup>15</sup> this paved the way for the now accepted technique of closed chest cardiac resuscitation. At the same time, in neighboring Philadelphia, Dr. Charles Bailey was among the pioneers in the use of the heart-lung machine for oxygenating patients during open-heart surgery. Meanwhile, Dr. Peter Safar was demonstrating at the Baltimore City Hospitals the value of mouth-to-mouth versus the time honored manual techniques of resuscitation.<sup>16-17,18</sup> We note again that this approach was not really as new as it seemed at the time. In Genesis, Chapter 2, Verse 7 we read,

"And the Lord God formed man of the dust of the earth, and breathed into his nostrils a breath of life; and man became a living soul."

As we can see, for many long years the anesthesia departments in both medical schools in the city suffered through turbulent times, with frequent changes in personnel and for a number of years without leadership. Dr. James Arnold, Professor Emeritus of Neurosurgery, recently summed up the past as follows: "Anesthesia in those (the early) days was a particular nightmare, . . . and the higher mortality at that time was due more to poor anesthesia than to operative procedure."<sup>19</sup> In the field of neurosurgery, in particular, Dr. Arnold would be the first to admit that one needs to walk a very narrow line to assign causality for mortality to anesthesia versus surgery. Nonetheless, he does convey an image of numerous, memorable, traumatic experiences.

Finally, two Princes came to town, saw the potential of the Sleeping Beauties, and clasped them to their breasts. Dr. Benson arrived at Hopkins in 1956; with little effort, he demonstrated his value to the staff and its patients; he remained for twenty years, succeeded recently by Dr. Eugene Nagel. Dr. Martin Helrich assumed his post as Chairman of the Department at the University of Maryland in the same year, and he is still with us. In contrast to a smattering of essentially review articles on anesthesia prior to his appearance, the department during his tenure has contributed more than 100 original articles to the medical literature.

And so, at the beginning of this century, anesthesiology was a toddling infant. A few pioneering, venturesome, and very talented individuals had the courage and also the foresight to devote their time and their efforts to this new field. During the period from that time until the present, the speciality has come of age. The current status of the field of anesthesiology is based upon enduring efforts in research, teaching, clinical care and organization on the part of staff physicians, both in the universities and in the community hospitals.

<sup>13</sup> Phillips, O.C., Frazier, T.M.: The Baltimore anesthesia study committee: Organization and preliminary report. *Anesthesiology* 18: 33-43, 1957.

<sup>14</sup> Phillips, O.C., Frazier, T.M., Graff, T.D., DeKornfeld, T.J.: The Baltimore anesthesia study committee: Review of 1,024 postoperative deaths. *J.A.M.A.* 174: 2015-2019, 1960.

<sup>15</sup> Kouwenhoven, W.B., Milnor, W.R., Knickerbocker, G.G., Chestnut, W.R.: Recent advances in surgery. *Surgery* 42: 550-561, 1957.

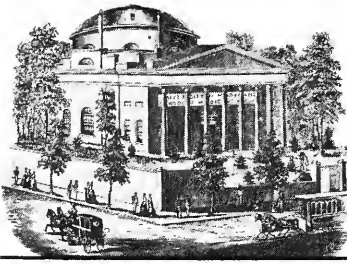
<sup>16</sup> Safar, P.: Ventilatory efficacy of mouth-to-mouth artificial respiration. *J.A.M.A.* 167: 335-341, 1958.

<sup>17</sup> Safar, P.: Failure of manual respiration. *J. Appl. Physiol.* 14: 84-88, 1959.

<sup>18</sup> Safar, P., Escarraga, L.A., Elam, J.O.: A comparison of the mouth-to-mouth and mouth-to-airway methods of artificial respiration with the chest-pressure arm-lift methods. *N. Engl. J. Med.* 258: 671-677, 1958.

<sup>19</sup> Arnold, J.G.: A history of the division of neurological surgery at the University of Maryland Hospital. *Bulletin, University of Maryland School of Medicine* 61: 17-18, 1976.

Ed. Note: Dr. Phillips is a member of the Class of 1942 and is presently Chairman, Department of Anesthesiology, Western Pennsylvania Hospital and Clinical Professor of Anesthesia, University of Pittsburgh.



# DAVIDGE HALL NOTES

Dedicated to the Restoration and  
Preservation of the Nation's Oldest  
Medical School Building

## DAVIDGE HALL COMMITTEE

John M. Dennis, M.D., '45  
John C. Dumler, M.D., '32  
William J. R. Dunseath, M.D., '59

John C. Krantz, Jr., Ph.D.  
Roger H. Michael, M.D.  
James A. Roberts, M.D., '46  
John O. Sharrett, M.D., '52

John A. Wagner, M.D., '38  
(Chairman)  
Theodore E. Woodward, M.D., '38  
George H. Yeager, M.D., '29

## Interim Report

The committee is pleased to announce that the Architectural Survey has been completed and a report has been received by the committee which is now studying the architectural findings. It is anticipated that a condensed report will be made available in the next edition of the *Bulletin*. In the meanwhile, a copy of the architect's report is available in the Alumni office in Davidge Hall.

With the appointment of an Executive Director by the Medical Alumni Association, increased promotional activities and fund raising may be expected during 1977.

The Davidge Hall Committee wishes to respectfully acknowledge the contributions of many alumni and friends towards this important project.

In the prior issue of the *Bulletin*, "major" contributors (those contributing \$1,000 or more) were listed. The following names were omitted from that list:

Richard H. Pembroke, Jr., M.D. '36  
Earl S. Shope, M.D. '65  
Kyle Y. Swisher, M.D. '48  
Rufus Thames, M.D. '54  
Enrique A. Vicens, M.D. '50

Listed below are special contributions and contributors of \$500.00 or more.

## Honorariums

Aaron Feder, M.D.

## Special Grants

Trustees of the Endowment Fund University of Maryland  
The Maryland Historical Trust

## Memorials

Frank H. Figge, Ph.D.  
Louis A. M. Krause, M.D. '17  
J. Grayson Luttrell  
Dr. Frank C. Marino Foundation, Inc.  
F. W. Mayer, M.D. '03  
William Andrew McMillan, M.D. '03  
W. K. McGill, M.D. '20  
Charles A. Reifschneider, M.D.

## Davidge Hall Contributors \$500—\$1,000

ACTON, Elizabeth, M.D. '43  
BALDWIN, Ruth W., M.D. '43  
BRANNEN, Joseph H., M.D. '45  
GANEY, Joseph B., M.D. '45  
HERALD, J.K., M.D. '35  
KARDASH, Theodore, M.D. '42  
KARNS, James R., M.D. '40  
KEISTER, Stephen R., M.D. '45  
LAPINSKY, Herbert, M.D. '39  
LERMAN, Phillip H., M.D. '44  
LEVICKAS, Herbert J., M.D. '46  
LEWIS, Jack C., M.D. '59  
METCALF, John W., Jr., M.D. '53  
MILLS, Lawrence H., M.D. '35  
MINERVINI, Robert V., M.D. '43  
NACHLAS, N. Edward, M.D. '47  
ORTON, T. Kenneth, M.D. '62  
PLUGGE, Frederick W., M.D. '57  
ROBERTS, Robert R.R., M.D. '54  
SHARRETT, John O., M.D. '52  
SIMMONS, William A., M.D. '57  
STARTZMAN, Henry H., M.D. '50  
WILHELMOSEN, Hans R., M.D. '59  
WILSON, J.D., M.D. '48

## Davidge Hall Contributors UNDER \$500

ANATOMY DEPARTMENT  
ABBOTT, Thomas G., M.D. '37  
ADAMS, John E., M.D. '56  
ADAMS, Thurston, M.D. '34  
AHROON, William A., M.D. '42  
AHLQUIST, Richard E., Jr., M.D. '52  
ALBRECHT, John G., M.D. '55  
ALMODOVAR, Ramon I., M.D. '43M  
AMOSS, Willard, P., M.D. '68  
AMSEL, Sheldon, M.D. Faculty  
ANDERSEN, Willie A., M.D. '70  
APPLEFELD, Mark M., M.D. '69  
APPLEFELD, Willard, M.D. '38  
ARCHAMBAULT, C. L. M.D. '69  
ARMACOST, Joshua H., M.D. '27  
ARNOLD, James E., M.D. '66  
ATKINS, John L., M.D. Faculty 99  
AUNGST, Melvin R., M.D. '35

(Additional donations to be continued in the next edition)

# PRESIDENT'S MESSAGE

James A. Roberts, M.D.



Hello Fellow Practitioners and Faculty:

The *Bulletin* is sent to 5,000 alumni, the faculty of the School of Medicine (both physicians and non-physicians) and all known physicians who have trained at the University Hospital complex, because the Bylaws of the Medical Alumni Association state that the above group is eligible for active membership. The Board of Directors of the Medical Alumni Association is convinced that the University of Maryland School of Medicine can remain at the "top of the list" with a team effort, and we ask your support in any way you see fit. The one suggestion I will make for supporting our school is to pay the annual dues of \$20 which will carry us a long way towards our goal without burdening a few.

Don't forget that Alumni Day will be June 1 and 2, 1977 at Hunt Valley and Davidge Hall. Please reserve the dates on your calendar and get your practice coverage early so that you can have fun without waiting for the phone to ring. Why don't you "talk it up" on your home grounds and come strongly represented.

The Fifth Annual Oyster Roast was held Friday, October 29, 1976 at the Hunt Valley Inn. The Junior Class was invited as guests of the Association, and other honored guests were Dean John M. Dennis, Chancellor Albin O. Kuhn, Associate Dean Morton I. Rapoport and Mr. G. Bruce McFadden, Administrator of University Hospital. About 110 students and their guests attended as well as 40 alumni and faculty members and guests. Mr. Ian Elliott, President of the Junior Class, thanked the Association on behalf of his class for a wonderful evening. I wholeheartedly endorse the Oyster Roast as an excellent social event involving students, faculty and alumni.

The Medical Alumni Association sponsored hospitality hours on Sunday, November 7, and Monday, November 8, 1976 at the Marriott Hotel in New Orleans, Louisiana on the occasion of the Southern Medical Association meeting. The social hours were held on the 37th floor where the view of the Mississippi River, with its teeming water traffic, was breathtaking, especially as the sun set and the lights came on. A highlight of the event was the presentation of the narrated slide production about Davidge Hall, which was well received by all viewers. Dr.

Julio E. Figueroa was our local host at the meeting and 35 members of the Medical Alumni Association and their guests were present, as well as the full Executive Committee, members of the faculty, Ms. Jessica Jane Radcliffe, representing the Junior Class of our Medical School, and Mrs. Jean D. Goral who registered and welcomed our members.

Mrs. Goral and I represented the Medical Alumni Association at the University of Maryland Alumni Association International Meeting held on the Catonsville Campus (6000 students) of the University of Maryland and I basically told the group the same things I am telling you in this column. I consider our attendance at these meetings vital in our public relations program and a crucial determining factor of our public image.

The Executive Committee is in the final stages of selecting an executive director and what a job this has been. I have at least an "inkling" of what it must be like to be on the admissions committee of the Medical School.

The research phase in the restoration of Davidge Hall was completed recently after four months or so of intensive efforts and a final report by the architect will be forthcoming early in 1977. Following that event, a super effort by the alumni, faculty, friends, etc. will be made and judgments concluded as to what should be done and what can be afforded in the final stages of the restoration program, namely the physical changes in the building.

If you have any suggestions about how the *Bulletin* may be improved, please let me know.

Dr. Henry Startzman, Chairman of the Constitution and Bylaws Committee, will be happy to consider any thoughts you may have relative to improvements in the Constitution and Bylaws. Please communicate with him through the Alumni office and if you desire a copy of the Constitution and Bylaws, we will be happy to send you one.

May each of you and yours have a very happy and healthy New Year.

See you soon,  
Jim Roberts



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## Alumni Reunion June 1, 2 and 3, 1977

### Wednesday, June 1, 1977

6-11:00 p.m., Cocktail Reception  
Davidge Hall

### Thursday, June 2, 1977

9:00 a.m. Registration,  
Davidge Hall  
10:00 a.m. Annual Business Meeting  
Scientific Session  
12:30 p.m. Alumni Lunch  
Student Union Building  
7:00 p.m. Reception, Hunt Valley Inn  
8:00 p.m. Annual Banquet, Hunt Valley Inn  
followed by program and dancing

### Friday, June 3, 1977

Commencement

### Ladies Activities

### Thursday, June 2, 1977

To be announced

### Class Reunions

1927, 1932, 1937, 1942, 1947, 1952, 1957, 1962,  
1967, 1972

## Harry M. Robinson, Jr. Clark Finnerud Award Recipient



On December 4, 1976, Harry M. Robinson, Jr., M.D., F.A.C.P., Class of 1935, Professor and Head of Dermatology at University of Maryland since 1954, was given the Clark Finnerud Award by the National Dermatology Foundation. The award, named for Clark Finnerud, a pioneer in Dermatology, is awarded annually to the physician, who is named by a committee, for teaching, research and contributions to Dermatology. The certificate award states—"To Harry M. Robinson, Jr., M.D. for his dedication to teaching and research in the field of Dermatology and for his inspired leadership of young physicians in his chosen specialty."

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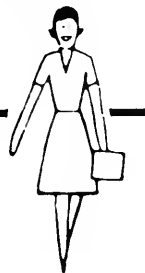
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The Medical Alumni Association wishes to express its appreciation to Mrs. Frank H. J. Figge, Dr. William L. Guyton, Dr. Milton C. Lang, Dr. Albert J. Mace, Mrs. Walter I. Neller and Mrs. John D. Pollard for their recent contributions of memorabilia to the Archives of the School of Medicine.

Following relocation of the Dean's Office to John Eager Howard Tower, space was allocated for an Archives Room and for cataloging and organization of historical memorabilia. It is hoped that many items can be placed on display during Alumni Day exercises.

The Medical Alumni Association would welcome artifacts and items of historical interest to add to its Archives.

George H. Yeager, M.D.  
Archivist

## DOCTORS' OFFICES CARROLL COUNTY

There exists a need for doctors in the Freedom District of Carroll County.

While this area has undergone tremendous residential, industrial and commercial growth, it has been overlooked by the medical profession.

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Applications are now being accepted for space in the complex. A descriptive brochure is available upon request.

For further information contact:

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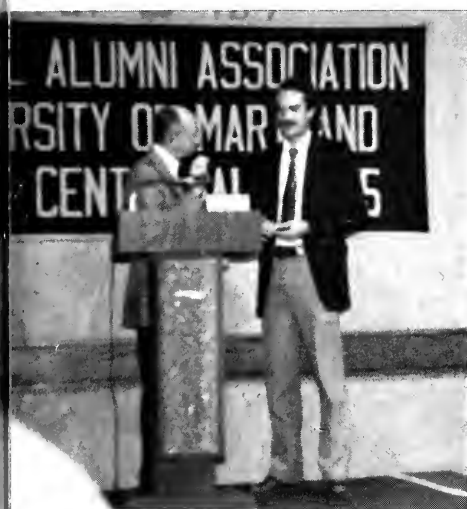


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## JR. CLASS OYSTER ROAST



James A. Roberts, M.D., President of the Medical Alumni Association, is assisted by Ian S. Elliott, President of the 1978 graduating class, in awarding door prizes.



Dr. H. Leonard Warres, 1938, appears to be "holding court" among alumni wives, Kathy Karpers and Marge Warres (standing) and Sue Donovan, Mary Helen Dennis, Carolyn Mullan and Mary Adele Roberts (seated, left to right).



Good food, good conversation—and a good time for the junior students!

# SOUTHERN MEDICAL ASSOCIATION MEETING

NEW ORLEANS, LA.

(Nov. 7-8)



Dr. James J. Cerda, 1961, Dr. Larry J. and Micky Warner, 1967, and Dr. George E. Urban, 1961.



Dr. James A. Roberts, President, making a point to Dr. Henry Langenfelder. Gentleman on right in light coat is Dr. Frank Greenwald, 1937.



Dr. Raymond M. Cunningham, 1939, talking with Alice and Dr. R. D. Richards, Faculty.



Kitty Langenfelder, Dr. Henry Langenfelder, Dr. David W. Palmer, 1939, Marge Cunningham and Betty Palmer.

# ALUMNI NEWS

*Elliot S. Cohen*, '68, Heidelberg, Germany, recently took over as Chief, Inpatient Psychiatry and Chief, Drug Abuse and Alcohol Rehabilitation Unit at the U.S. Army Hospital in Heidelberg.

...

*Stephen M. Adalman*, '67, Kingston, N.Y., was certified by the American Board of Ophthalmology in October, 1975. After a two-year interlude, including one year in Vietnam, he completed his residency at the Long Island Jewish-Hillside Medical Center in New York City. He is currently practicing in Kingston and is a Clinical Instructor at the Albany Medical Center.

...

*Timothy D. Baker*, '52, Baltimore, Md., was invited to present a paper on "The Future of General Practice—International Perspectives" by the Brazilian Medical Association at the World Medical Association Meeting in São Paulo, Brazil. Dr. Baker is currently Professor of International Health and Assistant Dean at Johns Hopkins.

...

*Joseph B. Bronushas*, '50, Baltimore, Md., Assistant Professor in Family Practice, University of Maryland Hospital, has been elected a Fellow in the American Academy of Family Physicians. This honor recognizes professional achievement and continuous educational attainments.

...

*Albert Steiner*, '37, Baltimore, Md., has been elected President of the American Rhinologic Society of which he has been a member since 1954. Dr. Steiner is Chief of the Department of Otolaryngology at Maryland General Hospital, as well as a member of the American Academy of Ophthalmology and Otolaryngology, the American Academy of Facial Plastic and Reconstruction Surgery and the Maryland Ear, Nose and Throat Society.

...

*John Z. Bowers*, '38, New York, N.Y., was awarded an honorary degree in science and humanities, Honoris Causa, by the University of

Aix-Marseille, France on October 11, 1976. In the citation he was described as a "Great friend of France" and a leading scholar on medical education in the world. He was also cited for his books on the history of medicine in Japan and China.

On November 15, 1976, Dr. Bowers was re-elected national President of Alpha Omega Alpha, the national honor medical society. This begins his third term in that distinguished office.

...

*Francis J. Townsend, III*, son of Francis J. Townsend, Jr., '42, of Ocean City, Maryland is in the Freshman Class at University of Maryland School of Medicine. "Townie" hopes to be the 3rd Dr. Townsend to practice in Ocean City.

...

*Jerry Herbst*, '71, Terre Haute, Indiana, is now in the private practice of Urology and has just recently been appointed Assistant Professor of Urology at Indiana University Medical Center as well as volunteer Assistant Professor of Biochemistry and Physiology.

...

*Morton H. Lipsitz*, '38, Buffalo, N.Y., F.A.C.P., D.I.M., Clinical Professor of Medicine at the University of Buffalo Medical School was presented a plaque for 35 years service to Buffalo General Hospital and promoted to the status of Senior Physician.

...

*Joel S. Gordon*, '63, Bethesda, Md., has been Chief of the Department of Ophthalmology at Suburban Hospital in Bethesda since 1974. He is also President of the Maryland Academy of Ophthalmology and is in private practice of Ophthalmology in Bethesda and Gaithersburg, Maryland.

...

*Karen S. Fountain*, '72, Rochester, Minn., has been appointed to the staff of the Mayo Clinic as a Consultant in Therapeutic Radiology. After internship at Maryland General Hospital, Dr. Fountain was a resident in Therapeutic Radiology at Univer-

sity of Maryland Hospital from 1973-74 and at Mayo Graduate School of Medicine from 1974-76. She is certified in Therapeutic Radiology by the American Board of Radiology. Dr. Fountain is also a member of the American College of Radiology, the American Medical Association, the American Medical Women's Association, the Radiological Society of North American and the American Society of Therapeutic Radiologists.

...

Frank A. Kulik, '68, Jackson, Miss., has been appointed Assistant Professor of Psychiatry at the University of Mississippi and Director of the Psychiatric Outpatient Department.

...

John P. Barthel, '51, Cedar Rapids, Iowa, has been appointed Campus Physician at Cornell College. Dr. Barthel has been in private general practice in Cedar Rapids since 1952 and will continue his practice while serving the Cornell community. Dr. Barthel interned at St. Luke's Hospital in Cedar Rapids and is a charter member of the American Board of Family Practice and a member of the American Medical Association and the Iowa Medical Society. He is a U.S. Army Medical Corps veteran of World War II, a councilman of the Mormon Church and a member of the Board of Mental Health Services. Dr. Barthel has also published various articles in medical journals.

## Help for the Alcoholic



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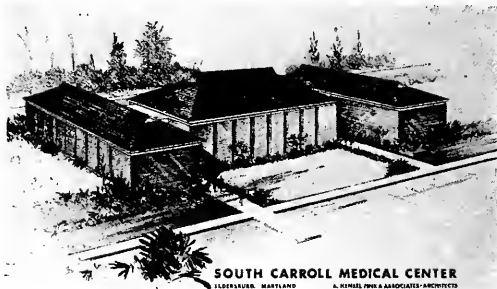
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# ALUMNI NEWS REPORT

## TO THE BULLETIN:

I would like to report the following: \_\_\_\_\_

[illegible]

## SUGGESTIONS FOR ITEMS

## American Board Certification

## Change of Office or Address

## Residency Appointment

## Research Completed

## News of Another Alumnus

## Academic Appointment

## Interesting Historic Photographs and Artifacts

## Scientific Articles

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Class \_\_\_\_\_

Send To: George H. Yeager, M.D.  
Editor, Alumni Bulletin  
University of Maryland  
School of Medicine  
Room 107 Gray Laboratory  
Baltimore, Maryland 21201

# FACULTY NEWS

## New Appointments, Promotions, and Resignations

Phillis M. Wise, Ph.D., Assistant Professor of PHYSIOLOGY, effective October 1, 1976.

Jay D. Haley, M.A., Clinical Professor of PSYCHIATRY, effective July 1, 1976.

Patti Seman, M.S.W., Instructor of PSYCHIATRY, effective October 1, 1976.

Emidio A. Bianco, M.D., Clinical Assistant Professor of FAMILY MEDICINE, effective October 1, 1976.

George J. Markelonis, Jr., Ph.D., Research Associate in ANATOMY, effective October 1, 1976.

David B. Graham, M.D., Assistant Professor of PEDIATRICS, effective September 1, 1976.

Jay A. Phillips, M.D., Instructor of PSYCHIATRY, effective September 1, 1976.

Bruce Regan, M.D., Instructor of PSYCHIATRY, effective September 1, 1976.

Susan F. Woolsey, M.S., Assistant Professor of PSYCHIATRY, effective September 7, 1976.

James McPhillips, M.D., Clinical Assistant Professor of FAMILY MEDICINE, effective September 1, 1976.

George M. Samaras, Ph.D., Assistant Professor of RADIOLOGY, effective July 1, 1976.

Sue A. Hudson, Ph.D., change in status to Research Assistant Professor of PHARMACOLOGY, effective July 1, 1976.

Sharon B. Satterfield, M.D., Clinical Assistant Professor of FAMILY MEDICINE, effective July 1, 1976.

James P. G. Flynn, M.D., Clinical Assistant Professor of SOCIAL & PREVENTIVE MEDICINE, effective September 1, 1976.

Judy Haran, M.S.W., Clinical Assistant Professor of PSYCHIATRY, effective July 1, 1976.

Sidney B. Seidman, M.D., Clinical Assistant Professor of PEDIATRICS, effective August 1, 1976.

Martin Wasserman, M.D., Clinical Assistant Professor of SOCIAL & PREVENTIVE MEDICINE, effective September 1, 1976.

Michael Salcman, M.D., Assistant Professor of SURGERY, effective June 1, 1976.

Paul D. Light, M.D., Assistant Professor of MEDICINE, effective July 1, 1976.

Elizabeth A. Hillman, Ph.D., Assistant Professor of PATHOLOGY, effective August 23, 1976.

Rosemary P. Rees, Ph.D., Assistant Professor of ANATOMY, effective September 1, 1976.

Ernest A. Austin, M.D., change in status to Assistant Professor of SURGERY, effective July 26, 1976.

Tomio Ichikawa, Ph.D., Visiting Associate Professor of BIOCHEMISTRY, effective July 1, 1976. (Appointment for one year)

Richard F. Morton, M.D., Clinical Associate Professor of FAMILY MEDICINE, effective July 1, 1976.

Donald J. Hobart, Ph.D., Associate Professor of PHYSICAL THERAPY, effective July 1, 1976.

Alfred Steinschneider, M.D., Ph.D., Clinical Professor of PEDIATRICS, effective November 1, 1976.

Thomas H. Morgan, M.D., Clinical Professor of SURGERY, effective June 7, 1976.

Margaret M. Fletcher, M.D., Clinical Associate Professor of SURGERY, effective May 1, 1976.

Akira Kitabatake, M.D., Visiting Associate Professor of SOCIAL & PREVENTIVE MEDICINE, effective September 1, 1976.

David A. Dobrow, M.D., Clinical Assistant Professor of PATHOLOGY, effective July 1, 1976.

Richard R. Graham, M.D., Clinical Assistant Professor of PATHOLOGY, effective July 1, 1976.

Paul G. Evans, L.L.B., Special Administrative Assistant of PEDIATRICS, effective August 30, 1976.

Robert G. Chambers, M.D., Clinical Assistant Professor of SURGERY, effective September 1, 1976.

Cyrus E. Beekey, Jr., M.D., Clinical Assistant Professor of MEDICINE, effective September 1, 1976.

Carlos Orbegoso, M.D., Clinical Assistant Professor of PATHOLOGY, effective July 1, 1976.

Phillip E. Jensen, M.D., Clinical Assistant Professor of PSYCHIATRY, effective October 1, 1976.

Leon P. Andrews, M.D., Clinical Assistant Professor of FAMILY MEDICINE, effective September 1, 1976.

Ramiro R. Lindado, M.D., Clinical Assistant Professor of PATHOLOGY, effective September 1, 1976.

Tai-San Huang, M.D., Clinical Assistant Professor of REHABILITATION MEDICINE, effective October 1, 1976.

Marianne E. Felice, M.D., Clinical Assistant Professor of CHILD PSYCHIATRY, effective July 1, 1976.

Marianne E. Felice, M.D., Assistant Professor of PEDIATRICS, effective July 1, 1976.

Raymond L. Clemmens, M.D., Clinical Associate Professor of PSYCHIATRY, effective July 1, 1976.



Kenneth B. Roberts, M.D., Clinical Assistant Professor of PEDIATRICS, effective August 1, 1976.

Robert J. Ayella, M.D., Clinical Professor of ANATOMY, effective August 30, 1976.

Charles A. Haile, M.D., Associate in MEDICINE, effective July 1, 1976.

Shambhu D. Varma, Ph.D., Associate Professor of OPHTHALMOLOGY, effective October 1, 1976.

Colin F. Mackenzie, M.D., change in status to Assistant Professor of ANESTHESIOLOGY, effective July 1, 1976.

Aden A. Burka, Ph.D., Instructor of PEDIATRICS, effective September 7, 1976.

John Gambrill, Jr., M.D., Clinical Instructor of OPHTHALMOLOGY, effective October 1, 1976.

Nancy Y. Rich, B.A., Educational Coordinator for the PROGRAM OF CONTINUING EDUCATION, effective September 13, 1976.

Steven H. Lamm, M.D., Clinical Assistant Professor of SOCIAL AND PREVENTIVE MEDICINE, effective October 1, 1976.

Edward E. Maher, M.D., change in status to Clinical Associate Professor of PEDIATRICS, effective July 1, 1976.

Saundra L. Warner, M.A., Assistant Professor of RADIOLOGY, effective July 1, 1976.

Kathleen R. Baker, B.A., Research Assistant in PEDIATRICS, effective September 1, 1976.

Charlotte R. Pool, Instructor of PATHOLOGY, effective September 15, 1976.

Duane L. St. Clair, M.S.W., Research Assistant in SOCIAL AND PREVENTIVE MEDICINE, effective September 7, 1976.

David E. Johnson, Ph.D., Clinical Instructor of MEDICINE, effective September 1, 1976.

Ronald M. Massey, M.D., Clinical Assistant Professor of SOCIAL AND PREVENTIVE MEDICINE, effective October 15, 1976.

Teresa Tiffert, M.D., Assistant Professor of PHYSIOLOGY, effective July 1, 1977.

Anabel D. Maxwell, M.S.W., Assistant Professor of PEDIATRIC SOCIAL WORK, effective September 8, 1976.

Jonathan F. Smith, Ph.D., Assistant Professor of MICROBIOLOGY, effective November 1, 1976.

Hayato Sanefuji, M.D., Research Associate in PATHOLOGY, effective October 15, 1976.

Harry P. F. Scholberg, Ph.D., Research Associate in BIOCHEMISTRY, effective December 1, 1976.

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# HISTORICAL PRINTS AVAILABLE

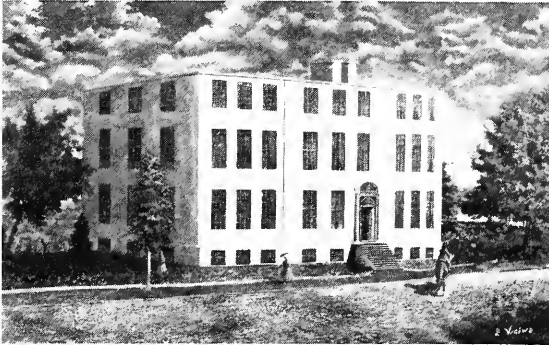
Several years ago two artists were commissioned to paint Davidge Hall and the three "old" hospitals: Baltimore Infirmary, 1823, and the University Hospital of 1870 and 1890.

High quality, signed and numbered reproductions of these original Historical Prints in a limited edition are now available. Arrangements have been made to mail one set of each of the four prints, accompanied by an insert describing the structures and artists, to those contributing \$150.00 to the Davidge Hall Restoration Fund.

**As the edition is limited, your early response is strongly advised.**

John A. Wagner, M.D.  
Chairman  
Davidge Hall Restoration Committee

(Note: individual prints are not available—prints can be sold in sets of four only.)



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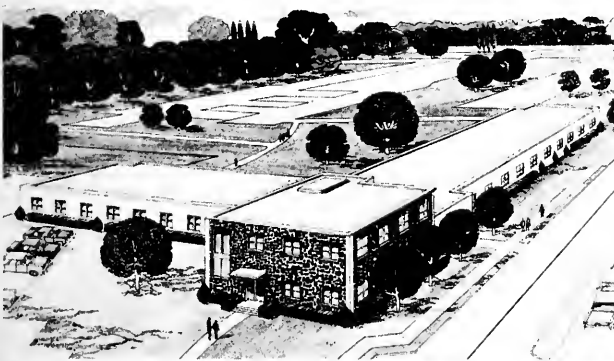
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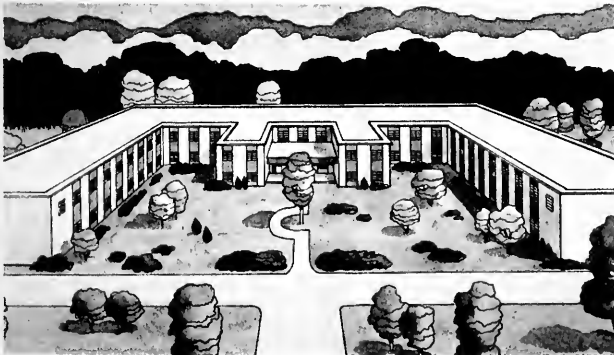
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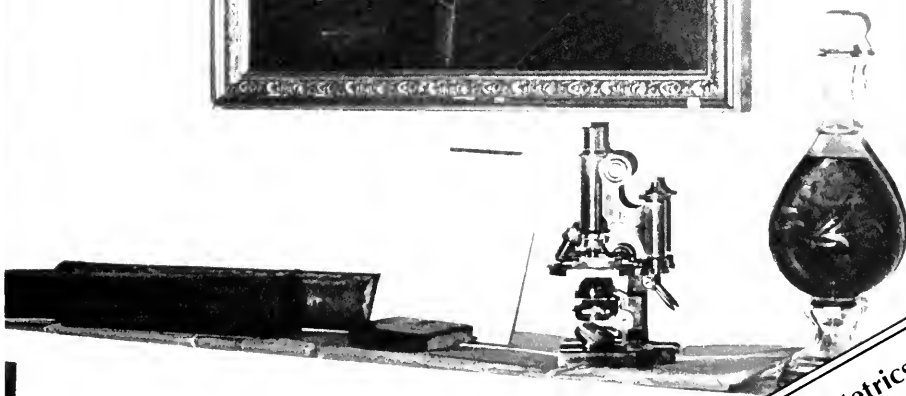
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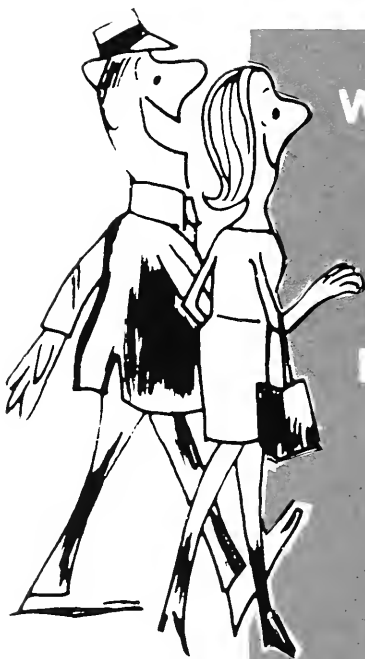
# BULLETIN

university of maryland school of medicine

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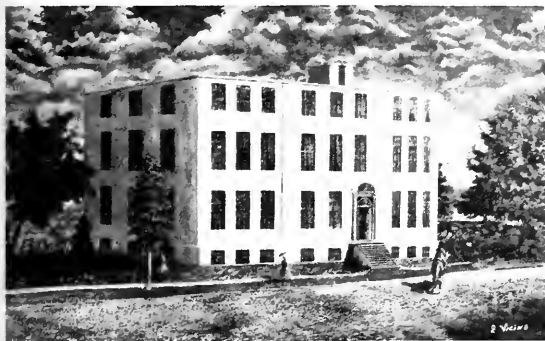
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COVER: Portrait of Dr. Nathaniel Potter and various artifacts in Davidge Hall Museum now being organized by Dr. George H. Yeager, Curator. (See page 29.)

# BULLETIN

**university of maryland school of medicine**

May, 1977

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# A Short History of the Teaching of Obstetrics and Gynecology at the University of Maryland

Arthur L. Haskins, M. D.

The origins of medical education generally and obstetrical teaching specifically in Maryland are not shared with the origins of the University of Maryland but rather are to be found among several dedicated physician teachers in the medical community of Baltimore.

While an attempt to found the University of Maryland by legislative edict in 1784 failed shortly thereafter, a viable educational unit for student teaching was in process of establishment by Dr. Charles Frederick Wiesenthal. Upon the death of Dr. Charles Frederick Wiesenthal, his medical school was inherited and operated by his son, Dr. Andrew Wiesenthal, in the city of Baltimore. George Buccannon, M.D., who had studied earlier under Charles Frederick Wiesenthal, enthusiastically joined with Andrew in the continuing effort to educate students of medicine.

Andrew Wiesenthal lectured in anatomy, physiology, pathology, surgery, and the gravid uterus to a class of fifteen students. At the same time, George Buccannon lectured in the diseases of women and children to a smaller class of nine students. These classes were singularly successful and stimulated the formation of a full faculty. In 1797, a Baltimore newspaper carried an account of this medical seminary with ongoing instruction in medical subjects. In the announcement, it was indicated that lectures on anatomy, surgery, and midwifery were given at the medical school by Dr. Andrew Wiesenthal.

Most influential in the developing medical educational scene was the arrival of Dr. John Beale Davidge in Baltimore in 1796. Dr. Davidge had received an M.A. from St. John's College in Annapolis in 1789 and his M.D. from Glasgow University in Scotland on April 22, 1793. Dr. Davidge was most important in urging the development of a college of medicine. As a result of his influence, John Shaw introduced a bill, "An act for founding a medical college in the city or precincts of Baltimore for the instruction of students in different branches of medicine." This bill was presented to the General Assembly of Maryland and passed unamended on December 18, 1807. Among its several provisions were a faculty and a Board of Regents.

The faculty that was chosen consisted of John Beale Davidge, M.D., and James Cocke, M.D., as joint professors of Anatomy, Surgery and Physiol-

ogy; George Brown, M.D., as professor of Chemistry; Thomas E. Burns, M.D., as professor of Materia Medica; and William Donaldson, M.D., as professor of the Institutes of Medicine. Thus the College of Medicine of Maryland became the fifth medical college in the United States. Its founding was preceded only by the University of Pennsylvania, Harvard, Dartmouth, and the College of Physicians and Surgeons of New York.

This small faculty group returned to Baltimore from Annapolis with a charter for a medical school but no provisions for its financial support. All equipment and buildings were to be provided by the faculty. Dr. Davidge, at his own expense, built a small anatomical theater which was subsequently razed by an outraged citizenry because of the anatomical dissection of human bodies within the building.

John Beale Davidge became Dean of the College of Medicine, a position which he retained until 1811. He also served as the Dean of the University of Maryland School of Physick, after the general assembly illegally obtained control of the College of Medicine through merger of its founding medical faculty with the additional faculties of Law, Arts and Sciences and Divinity.

During the early years there was no specific professor of obstetrics and many of the faculty were involved in the several aspects of obstetrics and gynecology. Professor Davidge expressed his views forcefully in gynecologic areas. He taught that menstruation was a secretion of the uterus excited by ovarian irritation. He was unalterably opposed to the support of the female perineum on the grounds that "nature was sufficient for her own processes" and declared himself against the vaginal speculum because it suggested immoral curiosity.

The continuing story of obstetrical and gynecologic teaching at the University of Maryland is to be found primarily in the history of the several professors in these disciplines who followed the first professorship in 1813.

## Professors of Obstetrics

RICHARD WILMOT HALL, M.D., First Professor of Obstetrics, 1813 to 1847.

On January 6, 1813, the Faculty of Physick began the process of carrying out the provisions of the new

act passed by the general assembly on December 29, 1812. These were mainly to appoint and annex itself to the three other faculties, the Faculty of Divinity, the Faculty of Law, and the Faculty of Arts and Sciences. At a Board of Regents' meeting on April 22, 1813, Robert Smith was elected provost and Richard Wilmot Hall, secretary.

Richard Wilmot Hall, M.D., became Professor of Obstetrics in the medical school in 1813 and continued in this capacity until 1847. Dr. Hall was born in Harford County in 1785 and was the son of a physician practicing in that county. He obtained his M.D. degree at the University of Pennsylvania Medical School in 1806 and settled in Baltimore to practice in 1811. One of the earliest known catalogues of the University is the one specifically for the Faculty of Physick for the session 1839 to 1840. Among the faculty listed was Richard Wilmot Hall, M.D., Professor of Obstetrics, Hygiene and Medical Jurisprudence.

Dr. Hall was appointed adjunct Professor of Obstetrics in 1812 and full Professor in 1813. During Hall's tenure as Professor of Obstetrics there was significant activity in gynecology although a department as such did not exist. In 1824, the year following the opening of the Baltimore Infirmary, Dr. Horatio Gates Jameson, University of Maryland Class of 1813, excised a cervix uteri, the first time that this operation was accomplished in either Great Britain or America.

Another important gynecologic personage to be identified with the University of Maryland Faculty of Physick was Ephraim McDowell. McDowell was born in 1771 and died in 1830. He was educated in a series of schools in Georgetown, Kentucky; Stanton, Virginia; and Edinburgh, Scotland. He was at the latter institution in 1793 and 1794 and then returned to the United States to practice in Danville, Kentucky.

On December 25, 1809, McDowell became famous as the first surgeon to remove an ovary by laparotomy. The significance of the surgery was recognized by the Faculty of Physick at the University of Maryland and the Board of Regents recommended that Ephraim McDowell be granted the honorary degree of M.D. on March 31, 1825. This, incidentally, was the only degree, either earned or honorary, that was ever granted to Dr. McDowell.

In this era, the College of Medicine was declared to be private property and not State-owned. The medical school experienced considerable unrest even among the members of the faculty. In 1843, the faculty brought charges against Richard Wilmot Hall, Professor of Obstetrics. The charges were: (1) refusing to comply with regulations of the faculty; (2) incompetency; (3) loss of confidence and respect of the profession.

Dr. Hall defended himself with such vigor that he retained his post until death. His trial created much controversy among the medical profession of Baltimore. The many students of Dr. Hall testified that he was a well educated man who taught in an admirable manner and held advanced views on such controversial matters as puerperal fever, eclampsia, and support of the perineum. The faculty, however, felt so strongly about their colleague and his alleged incompetency that Dr. William H. Stokes, who recently had returned from study abroad, was engaged to teach the same subjects. Both professors taught the same course during the same sessions which obviously caused great confusion among faculty and students. The controversy ended in 1847 upon the death of Richard Wilmot Hall.

RICHARD HENRY THOMAS, M.D., Second Professor of Obstetrics, 1847 to 1858.

Richard Henry Thomas was born in Anne Arundel County in 1805. He received the degree, Doctor of Medicine, from the University of Pennsylvania in 1828. Richard Henry Thomas was appointed Professor of Obstetrics and Medical Jurisprudence in 1847 at the age of 42. He was an excellent teacher with a reputation for lecturing without notes. "As an accoucher, he was always prompt, full of resources, and of great dexterity as a manipulator—few men in any calling have been more respected for sound attainments or more beloved for gentleness of manner and integrity of life." In addition to his practice and his activities in medical education, Dr. Thomas was a minister to the Society of Friends. He resigned his professorship in 1858, because of ill health, after eleven years of service. He died in 1860 at the age of 55.

GEORGE W. MILTENBERGER, M.D., Third Professor of Obstetrics, 1858 to 1891.

George W. Miltenberger was born in Baltimore in 1819. He received his M.D. degree at the University of Maryland in 1840. He was appointed demonstrator in Anatomy following graduation and became a lecturer in Anatomical Pathology in 1847. Prior to his appointment as Professor of Obstetrics, he was Professor of *Materia Medica* and Therapeutics in 1852 and was elected Dean of the Faculty of the School of Medicine in 1855. It would appear from Dr. Miltenberger's career that his primary interest was in the surgical specialties since in 1844 he presented "A full and complete series of lectures on operative surgery." This was the first time such a course had been offered.

Dr. Miltenberger became well known as a teacher and busy practitioner. He was said to be "a ready and pleasing lecturer, impressing his hearers with his honesty, his sincerity, and his mastery of the sub-

ject." Apparently he became quite wealthy as the result of his extensive practice and at one time was alleged to have eighteen horses for his personal use. In 1858, Dr. Miltenberger became Professor of the Department of Obstetrics which probably, at that time, also included at least part of gynecology as it is known today.

His service to the medical community was recognized in 1855 when he became president of the Baltimore Obstetrical and Gynecological Society and the following year president of the Medical Chirurgical Faculty.

A number of important medical and educational events occurred during Miltenberger's tenure as Professor of Obstetrics at the University of Maryland. Among these was the establishment of a new department, in 1867, in the field of diseases of women and children, probably the first such department in the United States.

Practical instruction at the University in obstetrics was improved by the purchase of a Pinard mannequin which was used in giving a practical course in palpation and operative delivery. The Board of Regents of the medical school purchased a large dwelling in the University Hospital neighborhood in 1888 for the care of free obstetrical patients. This Lying-In Hospital was well-staffed, two resident physicians responsible to a trained obstetrician, and represented significant progress in the proper care of the obstetrical patient.

Dr. Miltenberger retired in 1891 after 33 years as department chairman. He was made Professor Emeritus and Honorary President of the Faculty. He died in the early 1900's at about 90 years of age.

J. EDWIN MICHAEL, Fourth Professor of Obstetrics, 1891 to 1904.

J. Edwin Michael was born in Harford County in 1848 and received his M.D. from the University of Maryland School of Medicine in 1873. The year after his graduation he was appointed as a demonstrator in Anatomy and in 1880 he became a Professor of Anatomy. He was appointed Professor of Obstetrics in 1890. During his short term as Professor of Obstetrics he was also Dean and was, at one time, Professor of the Medical Chirurgical Faculty. In 1904, he contracted a chronic illness which debilitated him so that he was unable to continue teaching. He resigned as professor after 14 years in the position and died in 1905 at 57 years of age.

In the interval from 1904 to 1905 teaching was accomplished by Dr. Charles W. Mitchell who assumed teaching responsibilities without actually being appointed professor. Additional duties consisted of the instruction of therapeutics in the University of Maryland Dental Department, a department which has been operating as a distinct entity

since 1882.

During the years of Dr. Michael's chairmanship, Johns Hopkins Hospital was beginning to develop a teaching program in obstetrics and gynecology. In 1889, Dr. Howard A. Kelly was appointed gynecologist and obstetrician there. However, no obstetrical cases were admitted to that hospital until 1896. Although Dr. Kelly retained the title of Professor of Obstetrics and Gynecology until 1899, obstetrical teaching was to be the province of Dr. J. Whitridge Williams from 1894.

Dr. Williams received his M.D. degree from the University of Maryland in 1888. Subsequently, he studied Bacteriology and Pathology in Vienna and Berlin. He joined the gynecological-obstetrical staff of Johns Hopkins Hospital in 1889 only to return to Europe in 1894. At this time, he studied obstetrics in Leipzig. On his return to Baltimore, Dr. Williams became Associate Professor of Obstetrics and finally the first full Professor of Obstetrics at Johns Hopkins Medical School in 1899.

DR. LEONARD ERNEST NEALE, Fifth Professor of Obstetrics, 1905 to 1923.

Dr. Leonard Ernest Neale was born in Port Tobacco, Maryland in 1858. He was the son of a physician and a nephew of Dr. Miltenberger. He received his M.D. degree at the University of Maryland in 1881.

In addition to his obstetrical training with Dr. Miltenberger, Dr. Neale had the advantage of studying in European clinics and gaining some years of experience at the College of Physicians and Surgeons. It was said that he was probably better qualified as an obstetrical teacher and practitioner than any other obstetrician then residing in Baltimore or any of the teachers who had preceded him.

The teaching was didactic although hospital cases and deliveries were demonstrated to the student. The outdoor clinic was essentially unorganized. Outside cases were delivered by students who frequently secured their own cases by soliciting them in the poorer parts of town. These were seen by the obstetrical staff only in emergency situations.

In 1914 and 1915, the Physicians and Surgeons College of Medicine and the Baltimore Medical College merged with the University of Maryland School of Medicine. There were, as a result, three Professors of Obstetrics, Drs. Neale, Rowland and Dobson. Following the merger, each resigned his position so that there might be only one professor in the Department of Obstetrics. Dr. Rowland was appointed to this position for the newly formed medical school. Some of the outstanding men who served under Dr. Neale were Drs. N.L. Allen, E.H. Kloman, and Louis H. Douglass. Dr. Neale died in 1923 at the age of 65.

JAMES M. H. ROWLAND, M.D., Sixth Professor of Obstetrics, 1915 to 1937.

James M. H. Rowland was born in Liberty Grove, Maryland on February 14, 1867. He received his M.D. degree from the Baltimore Medical College in 1892. In addition to being a member of the faculty of the Medical School, he was an early faculty member of the University of Maryland School of Dentistry and was one of the faculty members when this school's curriculum was extended to four years in 1899. Dr. Rowland was a demonstrator in Anatomy in 1901 at the Baltimore Medical College and became Professor of Obstetrics in 1910. He was appointed Professor of Obstetrics at the University of Maryland in 1915 and became Dean of the School in 1917, a position he held until 1940. He resigned as Professor of Obstetrics in 1937 after serving in this post for 22 years.

Dr. Rowland published an article in the Maryland State Medical Journal in 1932 entitled, "Summary of Obstetrical Service in Baltimore from the late 1880's to 1926." Although there is little reference to his accomplishments in this monograph, it is obvious that he was greatly concerned by the indifference with which society and the medical profession treated obstetrical patients. He stated, "Drunks, venereal cases, prostitutes and all sorts of other cases have had freer access to free treatment at public expense than the expectant and the lying-in woman. No matter how dire the need of the obstetrical case, she was not considered a proper subject for public care. Even in the presence of eminent death, she was not a subject for hospitalization at public expense no matter how worthy. The cost of obstetrical care and the necessary attention is very great. No clinic demands more self sacrificing and painstaking care and no clinic has been so absolutely neglected in this State."

At this time the University of Maryland Hospital was operating 30 obstetrical free beds. In addition to this, through the outdoor clinic, Dr. Rowland developed a department of unusual size because of the 1500 women delivered in their homes. These were taken care of by a very well organized outdoor obstetrical service of the University Hospital.

In addition to his great efforts toward reforming obstetrical care in the State of Maryland, Dr. Rowland was also known as a champion of episiotomy and he further defined the contracted pelvis as a cause of dystocia. He died on July 26, 1954 at the age of 87.

DR. LOUIS HARRIMAN DOUGLASS, Seventh Professor of Obstetrics, 1937 to 1955.

Louis Harriman Douglass was born in Danville, Virginia on December 25, 1888. He was married in 1912 to Helen Rowles of Accomac, Virginia. There

were two children from this union, Jane and Anne.

Upon graduation from the Baltimore City College in 1907, he entered the University of Maryland School of Medicine. The degree of Doctor of Medicine was conferred on Louis Douglass on June 1, 1911. He was an intern the following year and was resident at the University Hospital from 1912 to 1913. From an appointment as Assistant in Obstetrics in 1915 through a series of promotions, Dr. Douglass became Professor and Head of the Obstetrical Department in 1937. His 48 years of association with the University of Maryland were interrupted only by a tour of duty in World War I in the United States Naval Reserve. He was honorably discharged from the Navy with the commission of Lieutenant, Senior Grade.

Upon his return from the service, Douglass became Chief of the Clinic of the Department of Obstetrics. The Obstetrics Dispensary was in the basement of the old University Hospital. It was at this time that Dr. Douglass recognized the importance of prenatal care. Prenatal care in those days was by modern standards crude and superficial. Routine blood studies were never carried out, patients were seldom weighed, and blood pressure was measured only if the patient exhibited relevant symptoms. The hospital was viewed as a last resort for the care of patients and then only if they had been in protracted labor in their homes.

The maternity inpatient area was on the second and third floors of a special wing over the nurses' dining room and was adjacent to the engine room and power house. Accommodations for private patients were practically non-existent. The service patient wing consisted of two twelve-bed wards, one for white and one for black patients. Since there was no elevator service for the ward patients, they were carried down a winding stairway for any operative procedure. All cesarean sections were performed in the main operating room of the hospital and this, of course, resulted in compromising delays because of the priorities assigned to other surgery. With an excellent background in clinical obstetrics and a dedicated desire to improve the care of the parturient woman, Dr. Douglass embarked upon a career in which he personally was to be greatly influential in improving maternity care in the State of Maryland. Dr. Douglass methodically developed a clinical organization which assisted him in applying his principles for the better care of the indigent mothers of Baltimore and Maryland. He not only assisted in the development of modern obstetrics at the University Hospital but also gave freely of his time to neighboring institutions. He was Chief Obstetrician at Provident Hospital in 1929. In 1931, he became Chief of the Obstetrical Service at Maryland General Hospital. In 1937, with the opening of Baltimore City

Hospitals, Dr. Douglass became the Chief Obstetrician at that institution. This new service was the largest in the city and cared for a large number of high risk patients.

The residency training at Baltimore City Hospitals and the University of Maryland Hospital were merged under the supervision of Dr. Douglass. Many of the residents, upon the completion of their education, were appointed to administrative positions in other hospitals. In 1955, at the time of his retirement, it was noted that fourteen of seventeen Baltimore hospitals with maternity services had at one time or another as their Obstetrician in Chief either Dr. Douglass or one of those whom he had trained. Douglass was recognized as an outstanding leader and innovator in the campaign to lower maternal mortality. He established the early prenatal clinics in the city of Baltimore. He worked with the Commissioner of Health to found the Bureau of Maternal and Child Hygiene in Maryland. He was a co-founder of the Maternal Mortality Conferences. He contributed to the work of the National Federation of Obstetric and Gynecologic Societies and was a supporter of the movement that resulted in the reconstitution of the Federation into the American Academy of Obstetrics and Gynecology. He assisted in the development of the Baltimore Rh-Typing Laboratory which was an unique contribution to the medical community sponsored by the Maryland State Obstetric and Gynecologic Society.

Among the many offices held during his career were President of the Maryland State Obstetric and Gynecologic Society and Chairman of the Section of Obstetrics and Gynecology of the American Medical Association. He was a member of the American Association of Obstetricians and Gynecologists and, in addition to his many other society memberships, was an honorary member of the Miami Obstetrical and Gynecologic Society, the South Carolina Obstetrical and Gynecologic Society, and the Virginia Obstetrical and Gynecologic Society.

At the time of his retirement in 1955, Dr. Douglass had realized, through his own efforts as well as with the support of his colleagues, the transition of primitive and uninterested obstetrics to a modern obstetrical service with an excellent teaching and service record. Thousands of medical students at the University of Maryland and hundreds of house officers received a better understanding of obstetrics as the result of Dr. Douglass' teaching. Dr. D. Frank Kaltreider, a previous student both at University of Maryland School of Medicine and Baltimore City Hospitals, as resident, was the principle mainstay in the Department of Obstetrics at the time of Dr. Douglass' retirement. Dr. Kaltreider was to continue in his role as teacher, clinician and researcher in the department until he was named Chief of the De-

partment of Obstetrics and Gynecology at the Baltimore City Hospitals in 1962.

### Professor of Gynecology

The motivation to form a Department of Gynecology probably is to be found in the interaction between two members of the faculty of the school of medicine, Dr. George Miltenberger, who was then Professor of Obstetrics and Dean, and Dr. William Travis Howard, who was adjunct to the chair of Physiology. When Howard was in the Department of Physiology there was only one graduate of the Maryland Medical School who had come from North Carolina. Howard's reputation was so favorable in the South that he influenced 18 students from North Carolina and 18 students from Virginia to attend the Maryland School of Medicine.

Apparently desiring a teaching discipline more clinically oriented, Dr. Howard made known his intention to resign to Dr. Miltenberger. Miltenberger urged that Howard remain on the faculty of the Medical School and further proposed the division of Obstetrics and Gynecology into two departments. He suggested that Dr. Howard be appointed to the proposed chair of Gynecology which encompassed the diseases of women and children. He was unanimously elected to this post on January 26, 1867, the department being the first of its kind in any of the medical schools in the United States.

WILLIAM TRAVIS HOWARD, M.D., First Professor of Diseases of Women and Children, 1867 to 1897.

William Travis Howard was born in Cumberland, Maryland on January 12, 1821. He was the son of William Howard, a noted architect. Howard's primary education was in the classical tradition, following which he attended Hampton Sidney and Randolph Macon. He first studied medicine under a preceptor, John Peter Mettauer, who was a Prince Edward County, Virginia surgeon. After this he attended Jefferson Medical College and graduated with an M.D. degree in 1844. After training as a resident student of medicine at the Baltimore City and County Alms House, he entered private practice in Warren County, North Carolina.

Dr. Howard migrated to Baltimore after the Civil War in part due to the unsettled conditions in the South at that time but probably contributed to by the death of his first wife, Rebecca Elizabeth Travis Anderson. While in North Carolina, an attack of the grippe left him in poor health with a permanent and persistent cough.

His election to the post of chairman of the Department of Diseases of Women and Children began a distinguished career in the teaching and practice of gynecology. He presented a complete set of lectures each medical school session in treatment and

diagnosis of diseases of women and children based largely on his own experience. His lecture material was collected by his students and eventually printed in book form. After this, Howard revised and updated the work annually.

In addition to his teaching endeavors, Dr. Howard authored clinical papers and was the inventor and modifier of gynecologic instruments. His bivalve vaginal speculum was used widely in this country. He was said to be the first to use Tarnier forceps in this country in 1881. He simplified the design of this basic forcep and instructed his students in its application and popularized its use in Maryland. He believed that the instrument facilitated rotation of the head from occiput posterior positions so that its use was not limited to cases where the head was at the pelvic brim but was used in positional problems as well. He also taught that it was unnecessary to remove the forceps when the head reached the pelvic floor so that delivery could be effected completely with this instrument. As a pioneer in the discipline of the treatment of women's diseases, Dr. Howard was the co-founder of the Hospital for the Women of Maryland in Baltimore. He is listed among the founders of the Baltimore Gynecologic and Obstetric Society and the American Gynecologic Society.

He was Vice-President of the prestigious American Gynecologic Society in 1880, a member of the Council in 1883, and the Society's President in 1885. Howard was also the President of the Medical and Chirurgical Faculty in 1902. After 30 years of service, Dr. Howard retired as Professor of Gynecology. It is said that his productiveness was so great during his tenure that the faculty selected three men to replace him. Dr. William Travis Howard died in Naragansett Pier, Rhode Island in 1907.

THOMAS ASHBY, M.D., Second Professor of Gynecology, 1897 to 1916.

Thomas Ashby was born near Front Royal, Virginia on November 18, 1848. His lineage included Lord Richard D. Ashby of South Cruxton, Quinby and Leichester, England. The cavalier Ashbys came to Virginia during the Cromwell protectorate. Colonel John Ashby, another ancestor of Thomas, distinguished himself during the French and Indian wars as a Company Commander during the ill-fated Braddock campaign. He was noted as a courageous and daring Indian fighter.

Thomas Ashby was an undergraduate at Washington and Lee University from 1867 to 1870 when Robert E. Lee was its president. He entered the University of Maryland School of Medicine in 1871 and graduated in 1873. Following an internship, he opened a private practice in Baltimore. He joined the faculty of the University of Maryland School of Medicine shortly thereafter as Professor of Anatomy.

In March of 1875 he was elected resident physician to the University Hospital.

The social well-being of women as well as their reproductive problems were a source of concern to Dr. Ashby and in 1882 he proposed the establishment of a women's medical college in Baltimore. That institution was subsequently created under his leadership and was distinguished for being the first in the South for the medical education of women. In the natural sequence of events, Dr. Ashby accepted the chair of Obstetrics at the Women's Medical College, a position that he held from 1882 to 1897. In 1889, he was appointed to the chair of Diseases of Women and Children in the Baltimore Medical College which, although only recently founded, had erected a college and hospital at a cost of more than one hundred and fifty thousand dollars. It ranked well academically among the medical schools in this country. He resigned his position at the Baltimore Medical College in July of 1897 when he was appointed Professor of the Diseases of Women at the University of Maryland School of Medicine. Among his many achievements, Dr. Ashby performed the first laparotomy for ruptured tubal pregnancy in Maryland.

Ashby's interest in the dissemination of medical knowledge stimulated him to become one of the founders of the Maryland Medical Journal. This journal was issued as a monthly until May 1880 when it became a biweekly with Dr. Ashby as its editor for fourteen years. He later became sole owner of the periodical which, at this time, was published weekly. The Journal was sold in 1888, presumably because of his increasing responsibilities as a gynecologic surgeon. He remained a frequent contributor to this and other medical journals and, in addition, published a textbook of gynecology.

The Medical and Chirurgical Faculty in 1890 elected Thomas Ashby as its President and he served as President at other times of the Baltimore Medical Association, the Baltimore Obstetrical and Gynecologic Society, and the American College of Physicians.

His interests were not limited solely to medicine for he became active in one of the largest fruit growing interests in Virginia and the director of the Commonwealth Bank of that state. He was elected to the Maryland State Legislature and probably is the only professor in the medical school who has ever served in that capacity. After a life of service, medical education, medical practice, and politics, Dr. Ashby died at the age of 68 on June 26, 1916.

WILLIAM SISSON GARDNER, Third Professor of Gynecology, 1916 to 1935.

William Sisson Gardner was born in Athens

County, Ohio on December 23, 1861. Gardner attended grade school and high school in Elkinsville, Ohio and later married Mary Maslin of Kent County, Maryland. He received his M.D. degree from the College of Physicians and Surgeons. He was resident physician at the Maternity Hospital in Baltimore, 1885 to 1886, and at City Hospitals of Baltimore from 1886 to 1887. From 1887 to 1893, he demonstrated obstetrics at the Maternity Hospital.

Dr. Gardner became Associate Professor of Gynecology in 1893 and was elected to the chair of Gynecology at the College of Physicians and Surgeons in 1905, a position held until 1915 when the College of Physicians and Surgeons became a part of the University of Maryland. He was elected by the Maryland faculty to the chair of Gynecology at the time of the merger.

Gardner's intellectual curiosity lead him to study the entity than known as milk fever. It was customary at that time to relate pyrexia in the puerperium with no other obvious cause to the engorgement of lactation that occurred three to four days postpartum. His observations led him to believe that milk fever was not a real entity and that lactation did not influence appreciably either the pulse or temperature. His major interests were in bacteriology and pathology and, despite the meagerness of his background curriculum, he became an able teacher in these fields.

Dr. Gardner contributed more than 54 monographs to the medical literature, the first in 1887 and the last in 1938. His textbook of gynecology was published in 1912. He was the president of the Medical and Chirurgical Faculty in 1921. His fruitful career was terminated on February 17, 1948, when he died at the age of 87.

JOHN MASON HUNDLEY, JR., M.D., Fourth Professor of Gynecology, 1936 to 1955.

The chair of Gynecology was not filled from 1935 to 1936. In 1936, Dr. John Mason Hundley, Jr. was appointed chairman of the Department of Gynecology.

John Mason Hundley, Jr. was born in Baltimore on July 8, 1891. His wife, Emily Holt, whom he married on December 1, 1923, was a native of North Carolina. There were no children from this marriage. Hundley received a bachelors degree from St. John's College in 1912 after which he attended Johns Hopkins School of Medicine for two years. He interrupted his studies at Hopkins to return to St. John's College for a masters degree which he obtained in 1914. Following this, he again resumed the study of medicine and was awarded an M.D. degree in 1916 from the Johns Hopkins School of Medicine. He was a house officer at the Union Protestant Infirmary from 1916 to 1918. Following this, he be-

came a Lieutenant in the Medical Corps of the American Expeditionary Forces and served overseas with the mobile operating unit.

Following the cessation of hostilities, he again became a house officer, this time at the University of Maryland in the Department of Gynecology from 1919 to 1921. He was proud to have served, in 1920, as a resident in Gynecology under the tutelage of his able father. The senior Dr. Hundley was respected as a competent gynecologist and teacher at the University of Maryland. John Jr. continued his association with the University of Maryland as an Instructor from 1921 to 1929 and an Associate in Gynecology from 1929 to 1936. He held a joint appointment at the Johns Hopkins Medical School as an Instructor in the Department of Gynecology from 1928 to 1936.

The female urology clinic at the University of Maryland Hospital was equipped by Dr. John Mason Hundley, Jr. as a memorial to his esteemed father. Dr. Hundley was also active in reorganizing the gynecologic dispensary and improving its teaching facilities. He became well recognized locally, as well as nationally, as a pioneer in the diagnosis and treatment of gynecologic cancer. In 1930, Dr. Hundley, with Dr. Grant E. Ward, established an oncology clinic at the University of Maryland Hospital which was the first organized cancer clinic in a hospital in the State of Maryland. Dr. Ward and Dr. Hundley purchased the radium used in the clinic for cancer therapy.

His fortunes were such that he was afforded the opportunity for further postgraduate studies in several European clinics in 1931. He was exposed to modern gynecologic endocrinology in the Women's Clinic at the University of Kiel under Professor Robert Schroeder. He was with the noted pathologist, Professor Robert Myer, at the University of Berlin and with Professor James Hayman of oncological fame at the Radium Hemet of Stockholm.

Upon his return to the United States, Dr. Hundley developed new research programs in gynecologic endocrinology in cooperation with the Obstetrical and Radiologic Departments of the University of Maryland and the Gynecologic Department of the Johns Hopkins Medical School. As the result of several years' investigation, he and his associates defined the endocrine causes of the urologic changes that occurred during pregnancy and, in 1935, presented the findings at the American Gynecologic Society an organization of which he was an avid supporter.

As the result of his clinical abilities, investigative programs, and teaching interests, Dr. Hundley was elected as chairman of the Department of Gynecology in 1936 by the faculty of the University of Maryland. In the years that followed, he became well



known as a gynecologic surgeon and as a female urologist. The department flourished under his stewardship which terminated with his retirement in the fall of 1955. Dr. and Mrs. Hundley continued to live in Baltimore until his death on December 18, 1965.

ARTHUR L. HASKINS, M.D., Professor of Obstetrics and Gynecology, 1955-.

Arthur L. Haskins was selected as chairman of the Departments of Obstetrics and Gynecology on January 1, 1955. In actuality, upon arriving in Baltimore he assumed chairmanship of the Department of Obstetrics and did not become chairman of the combined departments until the fall of 1955 at the time of Dr. Hundley's retirement.

Arthur L. Haskins was born in Philadelphia, Pennsylvania on March 31, 1917. He attended public grade school and high school and was graduated from the University of Rochester with a bachelors degree in 1938. He entered the University of Rochester School of Medicine in 1938 and graduated in March of 1943. While an undergraduate he became a fellow in Anatomy under Dr. George W. Corner. He married Kathryn Sara Burke on March 22, 1943 and they have four children: Arthur, Donald Burke, Mark, and Kathy Ann. Upon the completion of medical school, Dr. Haskins entered the United States Navy and served until his honorable discharge in August of 1947 at Lieutenant, Senior Grade.

Upon his release from active duty in the United States Navy, he entered the residency program in obstetrics and gynecology directed by Dr. Willard M. Allen at Barnes Hospital and St. Louis Maternity Hospital, both of which were associated with the Washington University School of Medicine. After completing one year of residency, he was awarded a United States Public Health Fellowship for research in reproduction. Upon completion of this year, he reentered the residency program and completed this on June 30, 1952. He was appointed Instructor in Obstetrics and Gynecology and then Assistant Professor, a position that he held until his appointment at the University of Maryland School of Medicine.

There were some significant trends nationally, concerned not only with the professional aspects of obstetrics and gynecology but also with the organizational concepts which greatly influenced the new department. The American Board of Obstetrics and Gynecology, which had previously granted certification in one or the other of the disciplines, now required that an applicant for certification be trained in both aspects of the program.

The majority of residency training programs in the country offered combined obstetrics and gynecology and, in most instances, the departments were combined as well under a single chairman. However,

several universities maintained separate Departments of Obstetrics and of Gynecology. These included the University of Maryland, Syracuse University, Albany Medical School, University of Oklahoma Medical School, and Johns Hopkins Medical School. Some of these separate programs included female urology and the diagnosis and treatment of breast disease in the Department of Gynecology. At the University of Maryland, the total urologic care of women was the responsibility of the Department of Gynecology.

The opinion of many of the leaders of obstetrics in the 50's was that obstetrics had progressed to its ultimate and further advancements would be minimal or unlikely. In their defense, it might be indicated that in all probability they were considering that the mechanical aspects of obstetrical practice had reached their ultimate without realizing that, with increasing scientific and physiologic knowledge of reproduction, obstetrical care would continue to improve more on a scientific than technical basis. The lessening of maternal mortality to an almost irreducible level led quite naturally to a greater emphasis on infant survival. The early beginnings of perinatology can be found in that era and we began to see more operative procedures for fetal distress and survival than in the earlier years.

A realization that the volunteer physician as teacher for both students and residents was, in most cases, impractical resulted in the development of the so-called full time faculty. The term became synonymous erroneously with the salaried faculty. In fact, the full time nature of the faculty member meant that his professional and teaching activities were confined to one institution and, thereby, would make him more immediately available for teaching and service. The resident physician began to receive more financial remuneration during his training years. There was decreasing emphasis on exploitation of the residents as cheap labor and more emphasis on the teaching responsibilities of the faculty and staff for the resident's education.

Research efforts were increased in the field of gynecologic endocrinology. Invasive techniques for studying the physiology of the fetus in utero were devised. The physiology of reproduction was becoming a fruitful area for investigation. Radioimmunoassay techniques were beginning to be developed that were later to be the foundation for the most informative radioimmunoassay endocrine investigations.

In some instances, paralleling the national trend, the situation at the University of Maryland School of Medicine also was modified by some specific local problems. The entire medical school was under academic probation because of accreditation difficulties. The teaching program emphasized diadac-

tic teaching and it was said that at one time the students attended approximately 1500 lectures per year. The medical school struggled within a budget restriction that allowed little for expansion.

In the Departments of Obstetrics and Gynecology there had been minimal cooperation and communication at the higher administrative levels although an arrangement to train the resident bilaterally in obstetrics and gynecology had been made. This consisted of a major and minor system in which the resident's training was either primarily obstetrics or gynecology, with residual time in the alternate specialty. In addition to the chairman of the Department of Gynecology, Dr. William K. Diehl and Dr. Everett S. Diggs were primarily concerned with the organization and administrative aspects of the Gynecology Department. Dr. D. Frank Kaltreider of the Department of Obstetrics was particularly active in all phases of the departmental responsibilities in service and teaching.

There was excellent service clinical material in obstetrics but not an equivalent amount in gynecology. The obstetrical clinic met daily; the gynecologic clinic met approximately two hours each day. Residents as well as the students were supervised by voluntary or part-time faculty. There was minimal faculty participation in clinical or laboratory research except for Dr. Kaltreider whose investigations into labor and pelvimetry were recognized nationally. In addition, a laboratory research program in the investigation of thyroid metabolism in pregnancy was well under way.

There were a number of affiliations with other hospitals in the city; the only meaningful ones, however, were at Baltimore City Hospitals and Peninsula General Hospital in Salisbury. The titular administrative head of the program at Baltimore City Hospitals remained the chairman of the Department of Obstetrics. However, in response to pressures from the Dean of the University of Maryland School of Medicine and the faculty at Baltimore City Hospitals, a search for a full time chief of Obstetrics and Gynecology was instituted and culminated with the appointment of Dr. Paul Molumphy as chairman of the Department at that institution. There was little rotation of residents from the University to the City Hospitals Obstetrical and Gynecologic Department, but fourth year medical students received four weeks of obstetrical and gynecologic experience there. Residents from University Hospital rotated through the service at Peninsula General Hospital and, on occasion, medical students in their fourth year visited this institution as well.

When the obstetric and gynecologic services were combined, the amount of training in each aspect of the discipline was equalized. There were, however, two levels of training, some residents completing the program in three years and others in four years.

The amount of time in obstetrics and gynecology

allotted to medical students was increased from six to ten weeks. The didactic teaching gradually was assumed by full time faculty, but with continuing help from those volunteer faculty who maintained an interest. Practical instruction as traditionally accepted was the province of the residents. Outside examinations were decided upon by the school as a method of determining objectively the quality of teaching. The examination that was chosen was the National Boards.

Beds were created especially for gynecology in the University of Maryland Hospital and special provisions were made for gynecologic-oncology and irradiation beds. Eventually the affiliations with Baltimore City Hospitals and Peninsula General Hospital were minimized, and, in the 1970's, close working affiliation was developed between the Departments of Obstetrics and Gynecology at the University of Maryland Hospital and Mercy Hospital. Dr. James P. Durkan was chosen from the faculty of the medical school to be chief of the Obstetric and Gynecologic service at Mercy Hospital. Student rotation was arranged and the residency programs were combined so that all residents spent equivalent time between the two institutions.

The author would be remiss if he failed to commend as individuals or as a group the many dedicated, voluntary physician-educators in obstetrics and gynecology who, throughout these one hundred and ninety-two years, have given unselfishly of their time and knowledge to the students who, in turn, continue the unending cycle of service to womankind and her progeny.

The author will leave the completion of the history of his tenure as chairman of the department to future interested historians whose views would necessarily be more objective. He wishes to express his gratitude to Mary Rebecca Middleton for her research efforts in the accumulation of much of the historical data quoted and to Margaret K. Evans for her departmental memories and secretarial assistance.

Material has been taken freely from:

1. *A University is Born*, by Margaret Byrnside Ballard, M.D., Garamond, Pridemark Press, Baltimore, Md. 1965.
2. Personal notes of Louis Harriman Douglass, M.D.
3. *Summary of Obstetrical Service in Baltimore*, from the later 1880's to 1926, by James M. H. Rowland, M.D. Reprinted Md. State Med. J. 46, Oct. 1975.
4. *Bulletin of the School of Medicine*, University of Maryland, Louis H. Douglass Number, 40: 1955.

Ed. Note: Dr. Haskins is Professor and Head, Department of Obstetrics and Gynecology, University of Maryland School of Medicine. Requests for reprints should be directed to Department of Obstetrics-Gynecology, University of Maryland Hospital, Baltimore, Maryland 21201.

# MARYLAND MEDICAL ALUMNI MEET IN NEW YORK

## MARCH 14, 1977

*The candid photos below were taken at a reception given by Dr. and Mrs. Jack A. Kapland (Class of 1937) honoring the Dean of the School of Medicine, John M. Dennis, M.D. The reception was held at the Kapland's home, 25 Central Park West in New York City, and attended by Maryland Medical Alumni in the area.*

George C. Peck, M.D., '53; Herbert Berger, M.D., '32 and James J. Stovin, M.D., '56

Dr. Kapland, Mrs. Kapland and Dean Dennis



Herbert Lapinsky, M.D., '39; William I. Wolff, M.D., '40 and Jacob B. Mandel, M.D., '41

Mrs. Herbert Lapinsky, Dr. Lapinsky and Dean Dennis

# The Baltimore Cancer Research Center at the University of Maryland Hospital

Michael D. Walker, M.D.

The Baltimore Cancer Research Center (BCRC) at the University of Maryland is a component of the Division of Cancer Treatment of the National Cancer Institute. It is a unique blend of determination by an intramural NCI Program and a major University with its various graduate schools and teaching hospital to improve the treatment and care of the cancer patient. Originating in the mid sixties, the BCRC first opened its doors as the Baltimore Chemotherapy Branch of NCI at the U.S. Public Health Service Hospital, Baltimore. Dr. Arthur Serpick was in charge of the clinical service. The first director of the BCRC was Dr. Jerome Block, who formally opened the BCRC in 1967 with a clinical operation consisting of the Sections of Medicine, Neurosurgery and Radiotherapy and the Laboratory of Pharmacology. The clinical programs of the BCRC were relocated to the University of Maryland Hospital in June of 1974, and its laboratory efforts will be moving to Howard Hall Towers within the year. Although there are now three distinct programs within the BCRC, they are specifically designed to complement and supplement each other's activities. The Clinical Oncology Branch, Laboratory of Molecular Biology, and Laboratory of Clinical Biochemistry carry out cancer research which runs the full gamut from basic molecular interactions to applied clinical research.

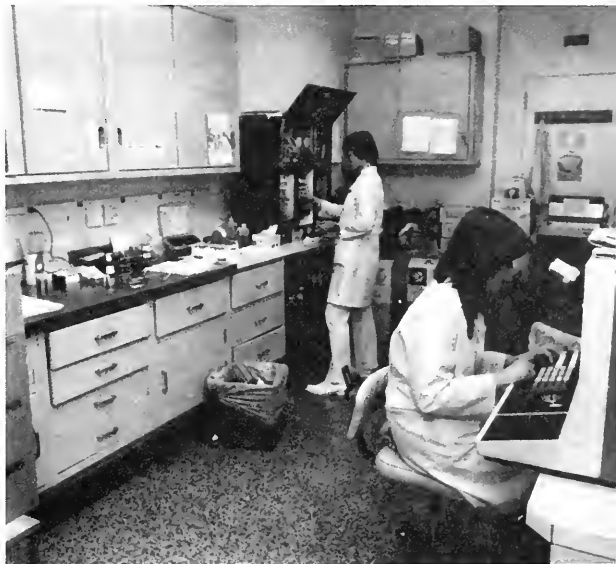
The senior staff of the BCRC is composed of permanent physicians and scientists, each a specialist. Junior staff are Clinical Associates provided through the NIH Matching Program (the equivalent of a Clinical Fellowship) and specialized Postdoctoral Fellows in the various laboratory areas. In the past, applicants have come from many of the major universities within this country, as well as from European and Japanese institutions. Although fellowships are normally for a two year period, Clinical Associates usually spend the first year in the clinical area learning the basic aspects of clinical oncologic research by direct responsibility for a limited number of patients under senior supervision. During the second year, they are assigned to work directly under a senior preceptor within one of the laboratory or clinical research areas. There are opportunities available

for several Clinical Associates who have developed active ongoing interests to stay for a third, and occasionally, a fourth year of investigation, research and training. The training in clinical and laboratory oncologic research is comprehensive and of a high level. The BCRC is proud that many of its graduates have positions of major responsibility in the new and growing cancer centers around the country.

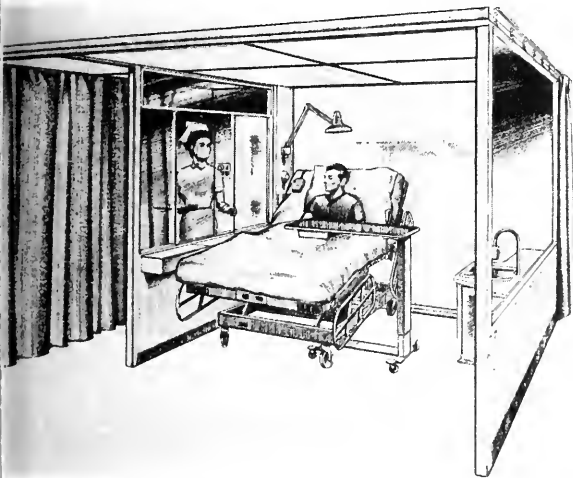
*The Clinical Oncology Branch* (Dr. Peter H. Wiernik, Chief) has as its first priority the provision of excellence in patient care from which a strong program in clinical research and cancer management can be derived. In so doing, new therapies are developed along rational scientific guidelines and examined carefully for their value. The Clinical Program is located on the ninth floor of the University of Maryland Hospital and is relatively self-contained with a specialized staff highly suited to its needs. Seven senior full-time physicians supervise aspects of the diagnostic, treatment and educational programs. In addition to the six first year Clinical Associates taken on each year, there are two Oncology Fellowships from the Baltimore Veterans Administration Hospital and rotations of residents from the Department of Medicine, as well as from other departments within the University Hospital.

The Center is designed around patient care and, therefore, the outpatient clinic, support services and inpatient areas are close to each other. The BCRC has its own "top flight" Nursing Service (Ms. Elizabeth O'Connell, Nursing Director). All 60 of the Nursing Staff receive special orientation and have been specifically trained in the therapeutic and research aspects of the program. Specialized nurses include Nurse Chemotherapists, who assist in the observation and treatment of patients; the Infection Control Nurse, who monitors infectious disease processes and educates patients; and a Psychiatric Liaison Nurse, who helps patients and their families through troubled times. In addition, a Home Care Nursing Service augments the physician staff in carrying through therapeutic programs, and a Social Worker and Research Dietician care for these specific needs of our patients.

The Infectious Research Section (Dr. Stephen C. Schimpff, Head) investigates new approaches for the treatment and control of infectious disease. Evaluation of protected environment (laminar air flow rooms) and new antibiotic regimens has begun to bring under study and control life-threatening infectious processes. A major concept is the early and extensive workup of all suspected infectious processes and the institution of immediate intensive antibiotic therapy. This must be followed with a prompt evaluation of the results of both diagnostic studies and the response to therapy with changes in treatment according to "on line information." These investigations are augmented by the Section of Microbiology, (Dr. Viola Mae Young, Head), which carries out detailed diagnostic and surveillance microbiologic control. Since diagnostic cultures frequently take several days to develop adequate answers, knowledge of the bacterial flora to which the patient has been exposed prior to his becoming infected permits the physician to make more educated, initial, therapeutic decisions.



Although laboratory support is provided by the University of Maryland Hospital laboratories, specialized tests are performed in BCRC laboratories such as this special hematology laboratory.



Laminar air flow rooms are used for the protective isolation of patients with a high risk of acquiring infection.

The BCRC has its own Hematology Laboratory nearby, which provides rapid and accurate hematologic determinations for both inpatients and outpatients. Frequently, as a result of either the disease process, treatment or a combination of both, patients become severely thrombocytopenic or granulocytopenic. In order to supplement the patient's temporarily compromised hematopoietic system, a Blood Cell Component Therapy Unit (under Drs. Charles Schiffer and Joseph Aisner) has the specific ability of providing platelets and granulocytes from selected donors. The BCRC operates a Patient Care Pharmacy Service (Mr. Clarence Fortner, Head) which fills the drug requirements for all patients being treated on BCRC regimens.

Record keeping is one of the major components of any therapeutic research facility. In order to provide rapid record retrieval and to collate the vast amounts of data generated, the BCRC maintains its own record room and computer facilities. Here, not only the daily care of the patient can be recorded and monitored, but studies of specific therapeutic regimens can be analyzed in detail. A full-time computer programmer, specifically trained in the analysis of clinical trials, assists the physicians and scientists of the BCRC in preparing and analyzing their data. A fully computerized system to retrieve medical records easily and promptly is being field tested with the hope of developing not only a computerized medical record keeping system, but one which will service educational purposes and provide in-depth, multi-variant analysis of selected patient populations.

The research programs currently include 25 treatment-oriented protocols: 16 chemotherapy or chemotherapy plus radiation studies, 6 infectious disease prevention or treatment evaluations, and 3 blood cell component therapy studies. Patients are admitted to the BCRC for treatment of specifically diagnosed diseases for which there are no acceptable standard treatments or for which the current standard therapy is recognized to be either essentially unsatisfactory or clearly in need of further refinement. A patient may be initially seen in the Out-patient Department, and, after a frank discussion of both the disease and treatment, evaluation and therapy may be undertaken. A patient who needs to be in the immediate vicinity for daily evaluation or

therapy but is not sick enough to be hospitalized may be entered into the Specialized Ambulatory Care Program (SACP) whereby he lives in a nearby hotel while not actively engaged in diagnosis or treatment. Patients who are in need of hospitalization are cared for on the inpatient service and may be in laminar air flow, intensive care or reverse isolation rooms, as required. As the diagnosis of cancer is made earlier and therapy is started before patients become critically ill, the initial management of the cancer patient has been gradually shifting toward the Outpatient Department.

The patients treated at the BCRC have adult acute leukemia, lymphoma such as Hodgkin's Disease, brain tumors, sarcomas, advanced metastatic breast cancer, oat cell carcinoma of the lung, or other less frequently encountered cancers. The BCRC has been in the forefront of the treatment of Hodgkin's Disease and both the techniques of diagnosis and response to therapy have improved dramatically in the last few years. Meticulous staging procedures, including the use of gallium scans, lymphangiograms and laparotomy with multiple node biopsy and splenectomy, have improved our ability to accurately stage a patient with regard to the anatomic extent of disease. As a result, therapy can be planned more appropriately so that today patients with Stage I, II and III A Hodgkin's Disease usually can be considered as curable. The control of more advanced Hodgkin's Disease, (Stage III B and IV), as well as the sequellae of long term therapy, is being evaluated.

Until recently, only about 30% of patients with acute myelocytic leukemia achieved a complete remission of their disease while, currently, the complete remission rate at the BCRC is better than 65%. This improvement is due to better basic drug therapy, improvement in blood component support, and advances in both infection control and therapy. Now that the majority of patients will achieve a complete remission, the next step is to evaluate intensively various methods for prolonging the length of complete remission by use of new drug therapy, immunotherapy and the prevention of central nervous system relapse.

Many common solid tumors have failed to respond adequately to therapeutic manipulations. Cancer of the lung, colorectal carcinoma, and breast cancer are beginning to respond marginally to single and multiple agent therapy. Among the most devastating and least responsive are brain tumors. The advent of rationally designed chemotherapeutic agents, such as the nitrosoureas (BCNU, CCNU and methyl CCNU), which can cross the blood-brain barrier are providing some hope in this disease. Newer agents are being tested in search for greater efficacy.

The Clinical Oncology Program collaborates in

cancer research and treatment with a host of other investigators. As a member of Cancer and Acute Leukemia Group B, BCRC investigators have both conducted the pilot studies which led to the design of new therapeutic protocols and served as national chairman for these studies. Three of the therapeutic modalities that have been or are being investigated by the Brain Tumor Study Group were previously studied at the BCRC for suggested therapeutic efficacy and safety. Specific interrelationships with the teaching programs in hematology and oncology of the Department of Medicine provide not only rapid dissemination of information but access to the latest in therapeutic concepts. Studies with the Departments of Surgery, Radiotherapy, and many other departments and divisions have led to the joint investigation and evaluation of new improvements with care of the cancer patient. There are also significant collaborative efforts with other National Cancer Institute investigators and numerous universities and cancer centers across the country.

One of the most important aspects for the BCRC is its involvement in educational programs. Medical students and residents in the Baltimore area may apply for elective rotations through the Clinical and Laboratory Programs of the BCRC. The Clinical Oncology Branch provides oncologic consultation service for the entire University of Maryland Hospital, as well as the Baltimore Veterans Administration Hospital. Although patient care oriented, these consultation services are organized so as to have direct educational benefit to house staff and students. Members of the BCRC staff serve on a wide variety of academic committees of the University and are committed to the enhancement and development of its educational programs. The BCRC has organized seminars in nursing and medical oncology and sponsors yearly a two and a half day symposium on the advances in cancer treatment research with nationally and internationally known speakers. The last of these was held on March 24-26, 1977 and covered specific topics of tumor management, oncogenesis, complications of therapy, and the rapidly evolving management of breast carcinoma. Students and researchers also may obtain training and experience in the Laboratory of Clinical Biochemistry and Laboratory of Molecular Biology, including the Section of Immunology and Cell Biology. Guest workers, from at home and abroad, frequently spend time in these areas studying new approaches in basic cancer research.

*The Laboratory of Clinical Biochemistry* (Dr. Nicholas Bachur, Chief) conducts a program of research that integrates biochemistry, pharmacology, molecular biology and clinical medicine. Investigations include those into cellular control mechanisms whereby new refined techniques are identifying and

defining the mechanisms by which endogenous and exogenous substances modulate cell proliferation and differentiation. The electron microscope is used to examine and to study cellular organelles ultra-structure and function in the normal and neoplastic state. Specific pharmacologic studies are carried out in drug disposition, metabolism and mechanism of action. Comparisons are made between normal and malignant cells *in vivo* and *in vitro* for quantitative and qualitative analysis of the cancer cell. Detailed comparisons then are made of the properties and kinetics of their cellular enzymes. Drugs and unusual chemotherapeutic agents serve both as tools for cellular and enzymatic manipulation, as well as specific study subjects.

Within the Laboratory of Clinical Biochemistry, pharmacology studies have ranged from the pharmacokinetics and drug metabolism of specific agents in patients to the study of molecular interactions between drugs and macromolecules. By comparing and combining observations and research data obtained at various levels, we are defining the site of action, mechanism of activation and mechanisms of toxicity of chemotherapeutic agents. The pharmacokinetics and metabolism of the anthracycline antibiotics daunomycin and adriamycin studied in conjunction with the Clinical Oncology Branch have helped to define specific metabolites as well as potential sites of action of these drugs. We can plan in addition, by studying the pharmacologic characteristics of drugs in man, therapeutic schedules designed on blood concentrations of drug rather than the clock. Studies on the intermodulating effect of one drug upon another have shown that the drug/drug interaction of streptozotocin and adriamycin causes alterations in hepatic metabolism of the latter and results in increased toxicity.

In these studies and in the study of cellular kinetics, cultured cells with normal and neoplastic properties are a major research tool. New analytic techniques are being developed for drugs and drug metabolites which can then be specifically applied to clinical pharmacologic problems. Close integration of fundamental laboratory research and clinical studies is a standard working approach of the laboratories of the BCRC. Prime leads then are brought back to the laboratory for more intensive scrutiny and manipulation under highly controlled circumstances. With the information derived from basic studies of cell control and drug cell interaction, alterations in old therapeutic approaches, as well as the development of new therapeutic concepts and agents for cancer therapy, are being developed.

The Laboratory of Molecular Biology (Dr. Carl C. Levy, Chief) has, as its prime objective, the study of the regulatory mechanisms of the cell. In this respect, nucleic acid metabolism has been investi-

gated with particular regard to the degenerative enzymes that are responsible for maintaining the levels of RNA and DNA in a cell. For example, messenger RNA (mRNA) with a long track of polyadenylic acid at its 3 prime terminus was found to be stabilized by the presence of adenylic acid polynucleotide. Mes-



Cell component therapy is an important adjunct to the supportive care of patients receiving chemotherapy.

senger RNA carries the translation data for nucleic acid replication. The stability depends upon an important characteristic of polyadenylic acid, namely, that of being a competitive inhibitor of cellular ribonucleases. These enzymes will bind or complex with polyadenylic acid and, in so doing, are prevented from attaching the messenger RNA itself. The removal of poly A from the messenger results in an elevated degradation of the messenger with concomitant loss of translation during protein synthesis. If a messenger RNA with its full complement of poly A is studied under the same conditions, translation of protein synthesis occurs without interruption. Thus, some of the basic regulatory mechanisms responsible for the maintenance of appropriate concentrations of RNA and DNA within the cell are being unravelled.

The metabolism of RNase has been studied in patients with multiple myeloma in whom extraordinary rises in serum ribonuclease activity have been described. However, 40% of the patients with multiple myeloma have severe kidney involvement, and there appears to be a specific interrelationship with those patients who have severe involvement and those who show elevation of RNase activity in the blood. Therefore, kidney disease is felt to be responsible for the inordinate rise in RNase and the latter is not directly related to the cancer itself.

The Laboratory of Molecular Biology has also concerned itself with the markers or footprints of cancer. When a tumor mass is so large that it can be measured with calipers or easily defined by x-ray, it is indeed a very large tumor containing often over



ten trillion cells. Vigorous therapy may reduce this to ten million cells ( $10^7$ ) which is so small that it cannot be found by conventional diagnostic techniques.

The polyamines (spermine, spermidine and putricine) have been shown to be present in increasing quantities in patients with cancer, and one of the goals of the laboratory is to develop more sensitive ways of quantitating these substances. Not only are they elevated in the cancer patient, but they also appear to play a role in modulating tumor metabolism. Other studies are in progress to more clearly demonstrate the effects on the cancer cell.

The Section of Immunology and Cell Biology (Dr. Michael Mardiney, Head) investigates the immunologic events as they may relate to cancer diagnosis and treatment. Studies have indicated that synthetic polynucleotides can successfully alter the survival of a high tumor strain of mice (the AKR mouse) and have further shown nucleolytic activity in several transplantable tumor systems. The modulation which immuno adjuvants can bring about in both the normal and neoplastic condition is being evaluated, with the hope that the host's own defense mechanisms may in some way be utilized from both a diagnostic and therapeutic point of view.

Although the clinics and laboratories of the Baltimore Cancer Research Center are staffed with full time faculty, ample opportunity for dialogue and cross-investigations between all the departments and divisions of the Medical School and the University of Maryland Hospital is provided. The BCRC is devoted to the concept of providing the optimum in clinical care, research and education. To that end, its laboratory programs will move down to the Howard Hall Tower 1, ninth floor, after the completion of modifications in that space. An anticipated overpass will physically bridge and scientifically interlink the clinical research areas on the ninth floor of the University of Maryland Hospital and research laboratories in Howard Hall. In addition to the EMI scanner which is already being used, there are plans for another linear accelerator and modernization and renovations in the clinical area. These are expected to enhance markedly our operational ability. The Outpatient Department will expand to cover more patients with comfortable treatment rooms and reduced waiting time. The Diagnostic and Special Study Laboratory facilities will be enlarged and the area for the provision of transfusions of whole blood, platelets or granulocytes will be increased. In the Inpatient Service, a new four bed Laminar Air Flow Unit, running "back to back" with a four bed Intensive Care Unit, will provide an extraordinary opportunity for investigation into these modes of care delivery. Upon completion of the modifications and renovations in both the laboratory and clinical pro-



Many receive their treatment in the Outpatient area.

grams, the BCRC will have an ultra modern, extremely efficient clinical and basic research laboratory facility on one level providing the optimum in geographic continuity. The unusual advantage of being incorporated within a large medical school facility brings to the BCRC superior support services in medicine, surgery, radiotherapy, radiology, nuclear medicine, etc. The complementary aspect of the coin is that the BCRC facility can provide, in return, excellence of patient care, research, and training. Over the course of the next several years, as the conquest of cancer program develops on a national level, the opportunity exists at the University of Maryland to capitalize on these associations and programs.

Ed. Note: Dr. Walker, Director of The Baltimore Cancer Research Center, is an Associate Director of the Division of Cancer Treatment, National Cancer Institute and Associate Professor of Neurosurgery at the University of Maryland School of Medicine.

The Baltimore Cancer Research Center accepts patients into therapeutic programs by referral from their physician. Treatment oriented protocols in leukemia, lymphoma, Hodgkin's Disease, brain tumor, testicular tumor, advanced recurrent breast cancer, and certain other solid tumors are being carried out. In addition, consultation in the management of specific cancer problems may be obtained. Physicians who wish to refer patients may do so by calling the Admitting Office:

Ms. Carole Rulenz: 301-528-7904 or

Dr. Peter H. Wiernik: 301-528-7912 Office  
301-730-6979 Home



# Seven Steps to CME Success:

## I. DETERMINING CONTINUING MEDICAL EDUCATION NEEDS\*

William F. Jessee, M.D.

In the last issue of the *Bulletin*, we explored the seven steps in the development of a personal learning plan for maintaining professional excellence (1). This article is the first of a series in which each of those seven essential steps will be examined in detail.

Adult learning occurs only when the individual feels a need to learn. Accordingly, the first step in developing an effective continuing medical education (CME) program is to determine your learning needs. A variety of techniques can be employed, but perhaps the simplest is to begin to list topics about which you wish you knew more or in which you feel a need for updating your knowledge. Give careful thought to the kinds of problems you see most frequently in your practice, for these are often fruitful topics for personal CME.

Be sure to consider also whether some non-medical learning might improve your effectiveness as a physician. For instance, is your *reading skill* adequate to handle the volume of educational materials that already come across your desk? Would better knowledge of office *organization and management* improve the efficiency of your practice and give you more time for both CME and leisure?

After exhausting the simple listing of subjects of interest to you and about which you wish to know more, you might wish to move on to more formal assessment of your personal learning needs. A number of tools have been developed by organizations which can be of considerable value to you. Many formal self-assessment programs are now available and the whole field is presently in a state of flux. Older tests are being revised, existing tests that seem to be good indicators of competence are being validated, and new tests are being planned. For current information, request the *Directory of Self-Assessment Programs for Physicians* from Department of Continuing Medical Education, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Your own specialty society is perhaps the best source for further information on self-assessment exams. With many specialty societies moving towards reexamination for recertification, the thrust towards making self-assessment tools available to their members is increasing. As you consider using

one of these tests, note carefully its nature and limitations and its relevance to the problems your patients bring to you. Some self-assessment examinations offer a measure only of your knowledge while others also measure understanding or diagnostic and treatment skills.

Also available are patient simulation models; some of which are highly sophisticated. Some of the best known were developed at the University of Illinois College of Medicine and are collected in a book entitled, "Clinical Simulation, Selected Problems in Patient Management." Prepared by the Interdepartmental Appraisal Committee of the University of Illinois, the simulations were edited by Christine McGuire and Lawrence Solomon. This book is available in many medical school bookstores or may be obtained directly from the publisher, Appleton-Century—Crofts Educational Division, 400 Park Avenue South, New York, New York 10016; the price, \$23.50.

Another system used by many physicians is the "Three By Five" system. This name comes from their practice of carrying around a small pack of 3 x 5 cards, or perhaps a small notebook, on which they make an entry whenever they run across something unknown. For instance, a question from a colleague to which one must reply, "I don't know," or a strange symptom associated with an otherwise familiar syndrome or an unexpected reaction to a drug or other treatment procedure should serve as a stimulus to make an entry into your notebook or on a 3 x 5 card. At the end of each day, dump your 3 x 5 cards into the "Ideas" folder of your learning file. At the end of each week, review these quick notes and translate them into learning needs for your preliminary listing.

Perhaps one of the most sophisticated ways of identifying learning needs is to profile your practice. The Department of Continuing Medical Education of the University of Wisconsin, 610 N. Walnut Street, Madison, Wisconsin, 53706 makes available an unusual service entitled "The Individual Physician Profile." This service provides an opportunity for you to study your own practice in detail, be tested on your patient problems, and receive educational suggestions which are based upon your learning needs. Upon enrolling in the program, you will be asked to

record all patient contacts one day a week for a month. This information then is coded and fed into a computer which generates 125-150 questions keyed to your "Practice Profile". After completing the test, you receive an hour telephone consultation in which you work with a trained educational specialist to plan your personalized continuing education program. The combination of data collection, testing and consultation produces a tailor-made CME program centered around clearly defined needs. The full program at Wisconsin—practice-profile, test, consultation, and learning prescription—is designed for family physicians. Members of other specialties, however, may take advantage of the first part (the practice profile). Cost of the complete service is surprisingly low.

Another source for such profiles is the College of Physicians of Philadelphia, 19 South 22nd Street, Philadelphia, Pennsylvania 19103. This organization, in collaboration with the National Board of Medical Examiners, has developed a Practice Related Educational Program (PREP) for primary care practitioners. Utilizing a practice survey to determine the health problems which a physician encounters in practice, they will develop a histogram which graphically represents the physician's individual practice profile. A variety of self-assessment tests then are provided to the physician, based upon the kinds of cases he sees, to allow him to assess his knowledge in these areas of greatest importance to his practice. Also mailed to the physician is a list of instructional materials pertinent to the particular area in which he took the pre-instruction test. He chooses the materials he wants to study and these are mailed to him by the College of Physicians. After an agreed upon period of time, the physician can take another self-assessment test covering the same health problem area tested at the beginning of the program. By comparing the results of both tests, he can determine whether he needs additional continuing medical education or whether he is satisfied with his progress.

In the near future, we hope to make such formal self-assessment tools available through the Program of Continuing Education of the University of Maryland. We feel that this service will be of considerable value to the practicing physician in identifying his own personal continuing medical education needs and taking that first important step towards developing a personalized learning plan which will assist in improving his capability to provide high quality medical care. In the next issue of the *Bulletin*, we will discuss the second step in the development of a personal learning plan, practice assessment.

In the meantime, we would like to extend a cordial invitation to all alumni of the University of Maryland School of Medicine to attend our Third Annual General Medical Review course, June 5-11, 1977, at the Hunt Valley Inn. Developed jointly by the Family Practice Program and the Program of Continuing Education, this one week review will be excellent preparation for the Family Practice Boards, as well as an opportunity for primary care physicians to update their knowledge in all areas of general medicine. For further information please contact our office at the following address: Program of Continuing Education, University of Maryland School of Medicine, 655 W. Baltimore Street, Baltimore, Maryland 21201.

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\* This series of articles is based on a booklet entitled, "Your Personal Learning Plan: A Handbook for Physicians", by Leonard S. Stein, Ph.D., published by the Illinois Council on Continuing Medical Education, Chicago.

#### Reference

1. Jessee, W.F., Continuing education: are you satisfied?, *Bulletin of the University of Maryland School of Medicine*, 62(1):13-14, 1977.

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Ed. Note: Dr. William F. Jessee is Assistant Dean for Continuing Medical Education, University of Maryland School of Medicine

#### PHYSICIAN

Full-time position available with twelve man multi-specialty group practice located in Eastern Baltimore County. The existing five-man Medical Department is searching for a General Practice or Family Practice physician licensed in Maryland. Partnership position is available. Excellent benefit program and salary commensurate with experience. Send curriculum vitae to: P. Piasecki, 1107 North Point Blvd., Suite 203, Baltimore, Md. 21224.

#### PHYSICIAN

Part-time position available for General Practice or Family Practice physician. Twelve man multi-specialty group practice located in Eastern Baltimore County. Afternoon, evening and Saturday morning hours available. Need coverage 18 hrs./week minimum. Send curriculum vitae to: P. Piasecki, 1107 North Point Blvd., Suite 203, Baltimore, Md. 21224.

# PRESIDENT'S MESSAGE

*James A. Roberts, M.D.*



Greetings Fellow Alumni:

It hardly seems possible this is my last communication through this column but according to my calendar it proves to be. My experiences serving as your President have been both enjoyable and challenging, and I honestly suggest it as a worthwhile and different diversion.

I wish to thank those of the Alumni office staff, especially Mrs. Jean Goral, for their untiring efforts in keeping this organization going full-steam through its 102nd year. Again, I want to thank the Board of Directors, all committee members, the Alumni *Bulletin* Editorial Board, the medical school faculty and students and hospital staff for their unselfish input into the smooth operation of this Association. Dr. John M. Dennis is proving to be the type of Dean we have been looking for, and we hope he stays for a long time. We pledge our continuing support to him and the School of Medicine. Chancellor Kuhn continues to be a genuine friend.

If you have any suggestions regarding alumni affairs, publications, etc., a Suggestion Box will be on hand in June, so please submit your contributions in writing, if you desire.

May I again remind you of our Alumni Reunion on June 1 and 2, 1977 (please check for details elsewhere in this issue). You will be sent information prior to the meeting, and I would greatly appreciate your giving this attention prior to arriving in Baltimore so you will be aware of all activities that have been planned. If you have questions, please call the Medical Alumni Office; 301/528-7454. Please plan to attend everything on the schedule because I know you will have fun doing so. We expect a lively business meeting, an exciting rededication of Davidge Hall as a National Historic Site and a tour of the present Medical School facilities, which I admit will be the first for me. Any of the wives who desire to

attend the Thursday morning meeting and then join us for lunch are cordially invited, if their husbands will sponsor them. You will note that there will be no Scientific Session as published earlier since we feel that you can survive without CME for one day.

Your evening on Thursday, June 2, will be spent at Hunt Valley Inn with a reception followed by dinner and dancing. This year you will have a choice between prime ribs of beef or rock fish stuffed with crab; both of which sound mouth-watering. May I suggest that you look over the list of graduating students and sponsor one or more by purchasing his ticket for the banquet.

The Class Captains have been hard at work setting up reunion activities for their respective classes. If you don't know who your Class Captain is, or have not received information in the mail regarding your reunion, please call us and we will fill you in on the plans.

I consider the following 1976-77 highlights;

- Davidge Hall research
- Rededication of Davidge Hall
- Medical School Tour
- Walter M. Winters, M.D. Scholarship Fund established
- Dr. Herbert Berger Lectureship established
- Legal and financial counsel obtained
- Recruitment of additional faculty as active Alumni members.
- Office of the Dean relocated in the new John Eager Howard Tower
- Bicentennial celebration
- Alumni Days 1977 June

Thank you for your attention and I will see you at Alumni Reunion.

Jim Roberts

# **Annual Medical Alumni Reunion and Rededication of Davidge Hall**

## **Wednesday, June 1, 1977**

6:00-11:00 p.m.      Cocktail Reception (Hot and Cold Hors d'oeuvres)  
Davidge Hall

## **Thursday, June 2, 1977**

9:00 a.m.      Registration and Refreshments  
Davidge Hall

9:30 a.m.      Welcoming Remarks: James A. Roberts, M.D., President Medical Alumni Association  
Albin O. Kuhn, Ph.D., Chancellor University of Maryland at Baltimore  
John M. Dennis, M.D., Vice Chancellor for Health Affairs; Dean, School of Medicine

9:45 a.m.      Presentation of 25-year Certificates

10:00 a.m.      Annual Business Meeting

11:30 a.m.      Rededication of Davidge Hall

12:00 noon      Tour of School of Medicine, Conducted by Dean John M. Dennis  
Followed by: Annual Alumni Luncheon, Terrace Room, Student Union Building

7:00 p.m.      Reception, Hunt Valley Inn, Main Ballroom

8:00 p.m.      Dinner

9:00 p.m.      Presentation of Honor Award and Gold Key  
Presentation of 50-year Certificates  
Followed by dancing to the orchestra of Mel Scherr (open bar)

## **Friday, June 3, 1977**

10:00 a.m.      Pre-commencement Exercises

3:00 p.m.      Commencement Exercises  
Baltimore Civic Center

## LADIES ACTIVITIES

All ladies are cordially invited to attend the Cocktail Reception on Wednesday evening, June 1, 1977 at Davidge Hall, as well as the Annual Reception and Banquet on Thursday evening, June 2, 1977.

An invitation is also being extended by the President, Dr. James A. Roberts, to all interested spouses to attend the Annual Business Meeting, Rededication of Davidge Hall, tour of the School of Medicine and the Alumni Luncheon on Thursday, June 2, 1977 beginning at 9:30 a.m.

The following activity has been planned for the ladies who wish to remain at Hunt Valley on Thursday, June 2.

11:30 a.m.—Lunch at the Hunt Valley Inn, followed by a film, "The Wonderful World of Flavor," and a tour of the Hunt Valley tea and extract manufacturing plant of McCormick & Co. The book, "Spices of the World Cookbook," published by McCormick & Co. will be presented to each person attending.

## ATTENTION GOLFERS

Arrangements have been made for our members at the Hunt Valley Golf Course (approximately four miles east of the Hunt Valley Inn); one of Baltimore's finest courses, for reserved starting time between 1:00 p.m. and 2:00 p.m. on Wednesday, June 1, 1977.

Members must provide own transportation; food and beverage available at the Hunt Valley Golf Club on an individual basis.

Mail your reservations early for guaranteed starting time.

## HOTEL ACCOMMODATIONS

(The Alumni Office will make reservations)

Hunt Valley Inn  
Interstate 83 at Shawan Rd.  
Hunt Valley, MD 21031  
Phone: 301/666-7000

The Baltimore Hilton  
101 W. Fayette St.  
Baltimore, MD 21201  
Phone: 301/752-1100

Holiday Inn—Downtown  
Lombard & Howard Streets  
Baltimore, MD 21201  
Phone: 301/685-3500

## PARKING FACILITIES

Wednesday evening  
June 1, 1977

Law Lot (entrance on Redwood St.)  
across from Visitors' Parking Lot;  
if full: Pratt St. Garage (entrance on Penn St.,  
between Lombard & Pratt)

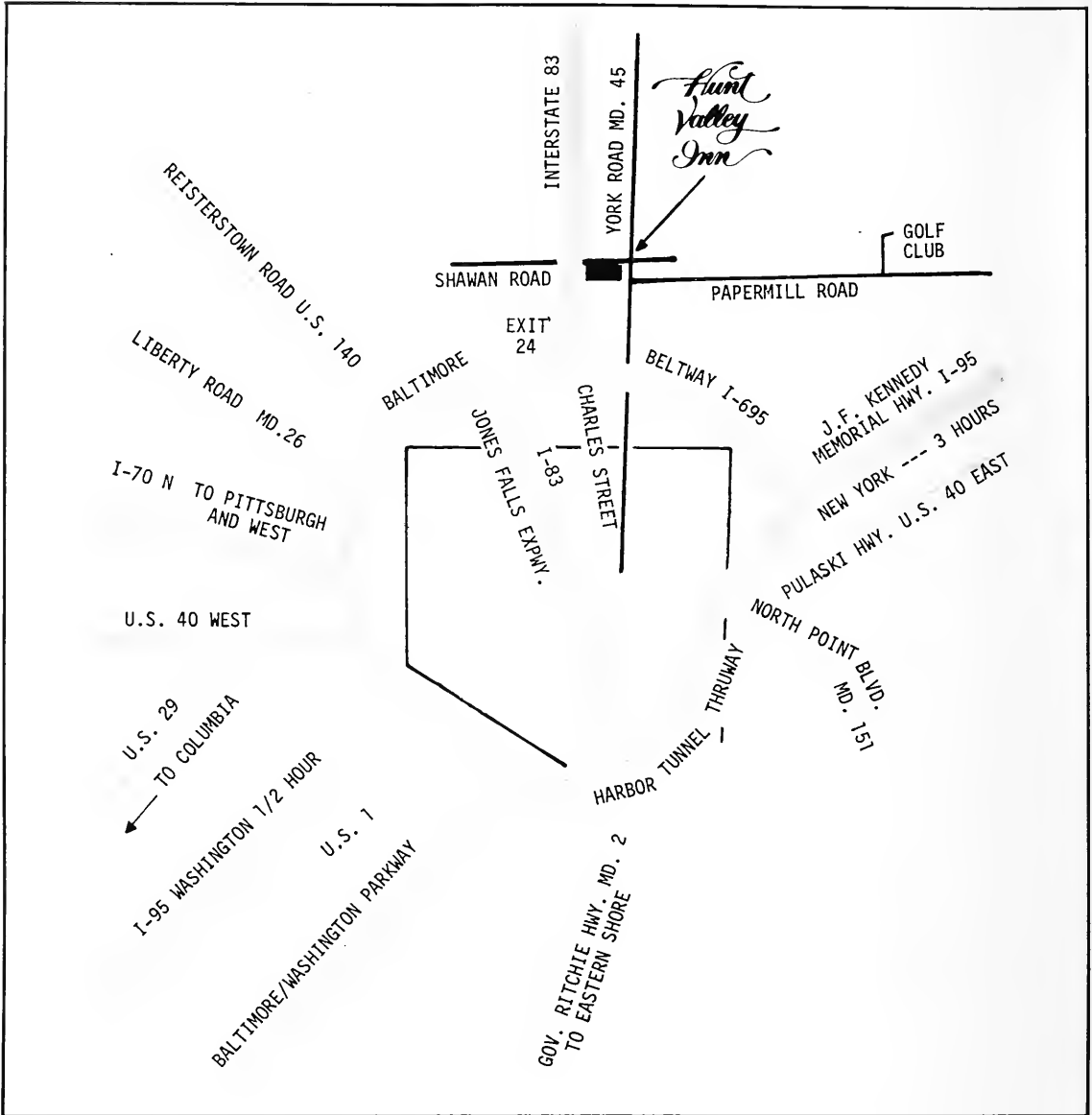
Thursday morning  
June 2, 1977

1. Pratt St. Garage (location above)
2. Fayette St. Garage (Fayette & Greene)
3. University Garage (Redwood St. & Penn)

## COURTESY BUS TRANSPORTATION

Transportation will be furnished for all functions during June 1 and 2, 1977.

## Map to Alumni Banquet



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# 102nd Reunion Activities

The Board of Directors of the Medical Alumni Association wishes to announce that the following alumni will be celebrating their 25th Anniversary of graduation from the University of Maryland School of Medicine. In recognition of their 25 years of service to the medical profession, individual certificates will be awarded at the Annual Business Meeting on Wednesday, June 1, 1977, to those alumni who have requested them.

## Class of 1952

Charles B. Adams, Jr., M.D.  
Benjamin A. Addison, M.D.  
Charles G. Adkins, M.D.  
R. E. Ahlquist, M.D.  
George C. Alderman, M.D.  
James W. Andrews, M.D.  
Raymond M. Atkins, M.D.  
Daniel Bakal, M.D.  
Timothy D. Baker, M.D.  
Edward H. Bergofsky, M.D.  
Oswald Berrios, M.D.  
Jack A. Bridges, M.D.  
Lowell E. Brittan, M.D.  
James B. Brooks, M.D.  
Wm. Morris Brown, Jr., M.D.  
John E. Carroll, M.D.  
Jack O. Carson, M.D.  
Daniel Clyman, M.D.  
Phin Cohen, M.D.  
Stuart P. Culpepper, M.D.  
Andrew J. Devlin, M.D.  
Andrew M. Diggs, M.D.  
Anthony J. Digiovanni, M.D.  
Robert A. Douglas, M.D.  
Robert C. Douglass, M.D.  
Wm. S. Dunford, Jr., M.D.  
Herbert L. Eckert, M.D.  
Lawrence D. Egbert, M.D.  
Lee W. Elgin, Jr., M.D.  
Charles S. Elliott, M.D.  
Jack Fine, M.D.

Michael J. Foley, M.D.  
Louis A. Fritz, M.D.  
Robert W. Gebhardt, M.D.  
Charles F. Gilliam, M.D.  
Paul H. Gislason, M.D.  
Luis F. Gonzales, M.D.  
Jay Calvin Gore, M.D.  
James R. Grabill, M.D.  
David E. Graham, M.D.  
C. E. Graybeal, M.D.  
Wm. R. Greco, M.D.  
Robert A. Grubb, M.D.  
Leon D. Hankoff, M.D.  
Wm. B. Harris, M.D.  
Wm. L. Heimer, M.D.  
Charles M. Holmes, M.D.  
Romulus V. Houck, Jr., M.D.  
Wm. B. Hudgins, M.D.  
Dewill T. Hunter, Jr., M.D.  
Laurel V. M. Hunter, M.D.  
Irvin Hyatt, M.D.  
Franklin L. Keller, M.D.  
Frank M. Kline, M.D.  
Joseph A. Knell, Jr., M.D.  
John M. Krager, M.D.  
Irving Kramer, M.D.  
Morton M. Krieger, M.D.  
Herbert W. Lapp, M.D.  
Charles H. Lightbody, M.D.  
Robert G. Love, M.D.  
William A. Mathews, M.D.

J. Nelson McKay, M.D.  
Richard Y. Olsen, M.D.  
Benton B. Perry, M.D.  
James S. Phelps, Jr., M.D.  
Wm. A. Pillsbury, Jr., M.D.  
G. Ramirez Santistebn, M.D.  
Jonas R. Rappeport, M.D.  
D. S. Rasmussen-Taxdal, M.D.  
Julian W. Reed, M.D.  
Malcolm L. Robbins, M.D.  
Wm. D. Rosson, M.D.  
Bella F. Schimmel, M.D.  
John O. Sharrett, M.D.  
Mahlon J. Shoff, M.D.  
Richard A. Sindler, M.D.  
Ursula T. Slager, M.D.  
Aubrey C. Smoot, M.D.  
Norton Spritz, M.D.  
Alvin A. Stambler, M.D.  
William R. Wolverton, M.D.  
Charles R. Starling, M.D.  
Belk C. Troutman, M.D.  
Carlos Vicens, M.D.  
Scott P. Wallace, M.D.  
Harry M. Walsh, M.D.  
Bryan P. Warren, Jr., M.D.  
John L. Watters, M.D.  
Howard N. Weeks, M.D.  
Albert J. Wildberger, M.D.  
John R. Wilkinson Jr., M.D.  
Donald A. Wolfel, M.D.

On the evening of Thursday, June 2, 1977 at the Hunt Valley Inn, the following members of the Class of 1927 will be honored and presented individual certificates commemorating their 50th Anniversary of graduation from the University of Maryland School of Medicine.

## Class of 1927

Joseph Adzima, M.D.  
Joshua H. Armacost, M.D.  
Capt. Claude R. Ball, MC USN  
John M. Bankhead, M.D.  
Julius W. Bell, M.D.  
John F. Cadden, M.D.  
Bernard J. Cohen, M.D.  
Raphael J. Condry, M.D.

E. Eugene Covington, M.D.  
Henry V. Davis, M.D.  
Sol M. Donchi, M.D.  
Harold W. Eliason, M.D.  
Jacob Feldman, M.D.  
Abraham H. Finkelstein, M.D.  
Joseph O. Fisher, M.D.  
Meyer H. Friedman, M.D.

Wade H. Garner, M.D.  
Abraham Gellar, M.D.  
Charles E. Gill, M.D.  
Bernard Glick, M.D.  
Isadore Goldberg, M.D.  
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**8th Annual University of Maryland Day  
Medical Alumni Conference  
Brunswick Hospital Center  
Amityville, New York  
October 15, 1977**

*Program*

- |                |   |
|----------------|---|
| 1:30 p.m.      | Greetings: Dr. Stein<br>Introduction: Dr. Dennis  |
| 1:45-3:15 p.m. | <i>Infectious Diseases: Recent Clinical Advances</i><br>Moderator: Dr. Kowalewski<br>Speakers: Dr. Rapoport<br>Dr. Hornick<br>Questions and Answers |
| 3:15-4:45 p.m. | <i>TRAUMA</i><br>Moderator: Dr. Jessee<br>Speakers: Dr. Mason<br>Dr. McLaughlin<br>Questions and Answers  |

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Dean, School of Medicine

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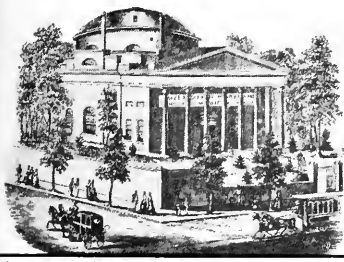
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# DAVIDGE HALL NOTES

Dedicated to the Restoration and  
Preservation of the Nation's Oldest  
Medical School Building

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## Rededication of Davidge Hall Planned for June 2

Davidge Hall, the nation's oldest medical school building still in constant use, has been declared a National Historic Site. A tablet commemorating this will be unveiled on the occasion of the Alumni Business Meeting on June 2, 1977. Dr. James Roberts, President of the Medical Alumni Association, will present Davidge Hall as a National Historic Site and as a priceless heritage of American medicine. Dr. Roger Michael, a member of the Davidge Hall Committee, will present a short biography of John B. Davidge for whom the hall is named. It is expected that a member of the Davidge family, now in its thirteenth generation, will be present to unveil the tablet to be presented to the School and the nation by Dr. John O. Sharrett, member and former Chairman of the Davidge Hall Committee. Dr. Sharrett was largely responsible for having the building declared a National Historic Site. It is hoped that the Rev. Dr. Gibson J. Wells will officiate at both the invocation and the benediction. A detailed program will reach each alumnus before the meeting.

## Davidge Hall Project Progresses

Continued discussions of proposals for the restoration and refurbishment of Davidge Hall are in progress. At this time, no definite conclusions have been reached. It is hoped that the Committee and the Medical Alumni Association will have a program available by the Medical Alumni Reunion Day on June 2, 1977. It is expected that this will be a part of the Davidge Hall Committee report.

## Davidge Hall Museum Organized Dr. George H. Yeager Named Curator

The Medical Alumni Association and the Davidge Hall Committee announces the organization of a museum and depository for medical archives with space consisting of three rooms located on the first floor of Davidge Hall. Dr. George H. Yeager, former Director of the University of Maryland Hospital and

recently retired President of Union Memorial Hospital in Baltimore, has assumed the task of collecting, cataloging and organizing material and related artifacts associated with the development of American medicine and, particularly, of the School of Medicine which will this year celebrate its 170th anniversary.

Those alumni and friends of the School of Medicine who wish to donate photographs, diplomas, publications or scientific instruments of an historical nature, should contact Dr. George H. Yeager at the following address:

Dr. George H. Yeager, Curator and Archivist  
Davidge Hall Museum  
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522 W. Lombard Street  
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## News of Another Alumnus

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Editor, Alumni Bulletin  
University of Maryland  
School of Medicine  
Room 107 Gray Laboratory  
Baltimore, Maryland 21201

# ALUMNI NEWS

*John P. Stone, '71, Windber, Pennsylvania, passed the American Academy of Family Practice Boards in 1976 and is Chief of Staff at Lee Hospital, Johnstown, Pennsylvania.*

...

*William O. Quesenberry, '70, Poway, California, has been in the private practice of Obstetrics-Gynecology in Poway for the past three years after a residency at University of California at San Diego. He was recently elected as President of the Medical Staff at Pomerado Hospital for next year. In 1975-76, Dr. Quesenberry served as Co-Director of the Ob-Gyn Residency Training Program at Mercy Hospital, San Diego.*

...

*John F. Kressler, '70, Arnold, Md., completed his General Surgery residency in June, 1975, and since that time he has been at Kimbrough Army Hospital where he is Chief of the Department of Surgery. In July, he plans to enter the private practice of surgery in the Arnold area. Dr. Kressler was certified by the American Board of Surgery in September, 1976.*

...

*William Smulyan, '69, Baltimore, Md., has become associated with Drs. Filtzer, Reichmister and Becker, P.A. in the practice of Orthopaedic Surgery in Baltimore.*

...

*Michael J. Deegan, '68, Ann Arbor, Michigan, will be leaving the University of Michigan this summer to join the Department of Pathology at the University of Pennsylvania as an Assistant Professor. Dr. Deegan hopes to extend his research activities in Immunopathology and Tumor Immunology while at Pennsylvania University.*

...

*Navy Medical Corps Lieutenant Commander John A. Bigbee, '67, Keflavik, Iceland, completed Navy Flight Surgeon training at Pensacola, Florida in December, 1976. During the six month training program, Dr. Bigbee received aviation officer indoctrination, didactic and clinical training in aviation medicine and six weeks flight training in the Navy's T-2 jet aircraft. He is presently on duty at Naval Station Keflavik, Iceland.*

...

*William E. Legat, '65, Bethesda, Md., has been elected Chairman of the Department of Psychiatry at Suburban Hospital in Bethesda. Dr. Legat is also in private practice in Bethesda and Chevy Chase. The Legats have three children and Mrs. Legat (Susan Traum) is also a member of the Class of 1965 of the University of Maryland School of Medicine.*

...

*Albert M. Gordon, '64, Annapolis, Md., is Assistant Professor at the Johns Hopkins School of Medicine and a member of the part-time staff of the John F. Kennedy Institute. Dr. Gordon's article entitled, "Progressive Quadriparesis . . ." was published in The Johns Hopkins Medical Journal 138, 1976. He has been in private practice in Annapolis since 1972 and in 1977 joined the partnership of Drs. Briscoe, Sutton, Fortier, P.A.*

...

*Donald M. Barrick, '62, Baltimore, Maryland, graduated with a degree of Juris Doctor from the University of Maryland School of Law in January, 1977.*

...

*Albert F. Heck, '58, Baltimore, Md., (Fellow in Neurology, Department of Medicine 1959-1962) has been appointed Professor and Chairman of the Department of Neurology at the University of Tennessee Center for the Health Sciences in Memphis. He will assume his new post on July 1, 1977. After two years active duty at Walter Reed Army Medical Center, Dr. Heck joined the faculty and staff of the University of Maryland and University of Maryland Hospital in 1964. He is currently Professor of Neurology, Director of the Stroke Clinic and Coordinator for the Cerebrovascular Research Center.*

...

*Ira N. Tublin, '54, Silver Spring, Md., has been elected Chairman of the Department of Internal Medicine of Holy Cross Hospital in Silver Spring.*

...

*Hilbert M. Levine, '54, Baltimore, Md., has been elected President of the Medical Staff and Chairman of the Medical Executive Committee of Mercy Hospital in Baltimore.*

(Continued on Page 34)



## ALUMNI NEWS

...

*Hugh V. Firor*, '53, Tucson, Arizona, has resigned the position of Director of Pediatric Surgical Services of Cook County Hospital and the University of Illinois Hospital to enter private practice in Tucson. In addition, he is an Associate in Surgery and Pediatrics at the University of Arizona School of Medicine in Tucson.

...

*Robert A. Douglas*, '52, Homestead, Florida, Associate Clinical Professor of Medicine, Department of Family Medicine, University of Miami School of Medicine, was made a Fellow in the Academy of Family Physicians during their Annual Meeting in Boston, Massachusetts in October, 1976.

...

*Joseph W. Scott*, '42, Miami, Florida, recently had his book for lay people entitled, *Woman, Know Thyself*, published by Charles B. Slack, Inc. Dr. Scott is a former Clinical Associate Professor of Gynecology at the University of Miami School of Medicine, and a Founding Fellow of the American College of Obstetrics and Gynecology and the American Society for Colposcopy and Colpomicroscopy. A Past President of the Miami Obstetric-Gynecologic Society, Dr. Scott is also a Fellow of the American College of Surgeons, a member of the American Medical Association and the Florida Medical Association.

...

*Julian G. Kirchick*, '40, Plainview, New York, is a Fellow in the American College of Surgeons and was appointed Assistant Professor of Clinical Surgery at the State University of New York Medical School at Stony Brook. Dr. Kirchick practices Otolaryngology in Plainview, Long Island, New York.

...

*John J. Bunting*, '38, Houston, Texas, is recovering from a right leg amputation below the knee as a result of a horse accident 7 years ago. Currently, he is awaiting stump-healing and a proper prosthesis. However, Dr. Bunting still rides and has his "Texas horses" and practice.

...

*Robert Perlman*, '30, Cincinnati, Ohio, was promoted to Clinical Professor Emeritus of Orthopedic Surgery of the University of Cincinnati College of Medicine, effective September, 1976.

## FACULTY NEWS

### New Appointments, Promotions, and Resignations

Alberto C. Seiguer, M.D., promoted to Instructor of Pathology, part-time, effective September 1, 1976.

Malka Scher, Ph.D., appointed to Research Associate in Biochemistry, effective October 31, 1976.

Rustum Irani, M.D., appointed to Clinical Instructor of Medicine, effective July 1, 1976.

Judith Tormey, Ph.D., appointed to Assistant Professor of Psychiatry (Philosophy), effective September 1, 1976.

J. Eugene Robinson, Ph.D., appointed to Professor of Biophysics, effective September 1976.

Lawrence Goldman, Ph.D., appointed to Professor of Biophysics, effective July 1, 1977.

Kay Wallis, M.S., appointed to Assistant Professor of Nursing in Psychiatry, effective September 1, 1976.

Antonio C. Oliveira, M.D., Ph.D., appointed to Visiting Research Assistant Professor of Pharmacology, effective September 27, 1976.

Charles L. Whitfield, M.D., appointed to Associate Professor of Medicine, effective October 1, 1976.

Patricia A. Grady, Ph.D., appointed to Research Associate in Neurology, effective November 2, 1976.

Ronald F. Abercrombie, Ph.D., appointed to Assistant Professor of Biophysics, effective September 30, 1976.

Anna Rosenberg, Ph.D., appointed to Clinical Assistant Professor of Psychiatry, effective October 27, 1976.

David R. Nalin, M.D., appointed to Assistant Professor of Medicine, effective December 5, 1976.

Victor R. Hrehorovich, M.D., appointed to Associate Professor of Medicine, effective July 1, 1976.

Abram B. Fajer, M.D., Ph.D., appointed to Clinical Professor of Obstetrics and Gynecology, effective December 1, 1976.

Stephen Fuller, M.D., appointed to Instructor of Surgery, effective November 23, 1976.

Bassam Y. Barakat, M.D., appointed to Assistant Professor of Obstetrics and Gynecology, effective January 1, 1977.

- Bruce Berger, M.D., appointed to Instructor of Surgery, effective November 1, 1976.
- Mishrilal Jain, Ph.D., appointed to Research Associate in Psychiatry, effective January 1, 1977.
- Robert J. Kokoski, Ph.D., appointed to Research Associate in Psychiatry, effective January 1, 1977.
- Albert Kurland, M.D., appointed to Research Associate in Psychiatry, effective January 1, 1977.
- Thomas E. Hanlon, Ph.D., appointed to Research Associate in Psychiatry, effective January 1, 1977.
- Roland L. Fischer, Ph.D., appointed to Research Associate in Psychiatry, effective January 1, 1977.
- David N. Nurco, D.S.W., appointed to Research Associate in Psychiatry, effective January 1, 1977.
- William A. Richards, Ph.D., appointed to Research Associate in Psychiatry, effective January 1, 1977.
- John Rhead, Ph.D., appointed to Research Associate in Psychiatry, effective January 1, 1977.
- Oliver McCabe, Ph.D., appointed to Research Associate in Psychiatry, effective January 1, 1977.
- John R. Lenox, Ph.D., appointed to Research Associate in Psychiatry, effective January 1, 1977.
- Richard VonKorff, Ph.D., appointed to Research Associate in Psychiatry, effective January 1, 1977.
- Clinton C. Brown, Ph.D., appointed to Research Associate in Psychiatry, effective January 1, 1977.
- Althea Wagman, Ph.D., appointed to Research Associate in Psychiatry, effective January 1, 1977.
- John H. Seipel, M.D., appointed to Research Associate in Psychiatry, effective January 1, 1977.
- Reuben Sawdaye, Ph.D., appointed to Research Associate in Psychiatry, effective January 1, 1977.
- Bradford Yates, M.A., appointed to Research Assistant in Psychiatry, effective January 1, 1977.
- Edwina Wilkinson, appointed to Research Assistant in Psychiatry, effective January 1, 1977.
- Dennis E. Upright, B.S., E.E., appointed to Research Assistant in Psychiatry, effective January 1, 1977.
- Ann T. Summerfelt, B.A., appointed to Research Assistant in Psychiatry, effective January 1, 1977.
- Dorothy A. Sullivan, B.S., appointed to Research Assistant in Psychiatry, effective January 1, 1977.
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- Andrew B. MacKay, A.B., appointed to Research Assistant in Psychiatry, effective January 1, 1977.
- Nancy J. Horrom, A.B., appointed to Research Assistant in Psychiatry, effective January 1, 1977.
- Ellen G. Ressin, M.A., appointed to Research Assistant in Psychiatry, effective January 1, 1977.
- Francis J. Schuster, A.B., appointed to Research Assistant in Psychiatry, effective January 1, 1977.
- Willie O. Cartwright, M.S., appointed to Instructor of Medical Technology, effective January 1, 1977.
- Susan L. Gold, M.S., appointed to Instructor of Surgery, effective January 10, 1977.
- Perry Shelton, M.D., appointed to Instructor, Family Medicine, effective January 1, 1977.
- Nancy S. Williams, M.S.P.H., appointed to Research Associate in Social and Preventive Medicine, effective February 1, 1977.
- Walter Schurch, M.D., appointed to Associate in Pathology, effective January 1, 1977.
- Doris S. Thornton, M.S.W., appointed to Instructor in Psychiatry, effective January 3, 1977.
- Martin A. Robbins, M.D., appointed to Clinical Assistant Professor of Surgery, effective December 1, 1976.
- Morikazu Shinagawa, Ph.D., appointed to Visiting Assistant Professor of Biochemistry, effective February 13, 1977.
- Allen P. Fertziger, Ph.D., appointed to Associate in Social and Preventive Medicine, effective January 24, 1977.

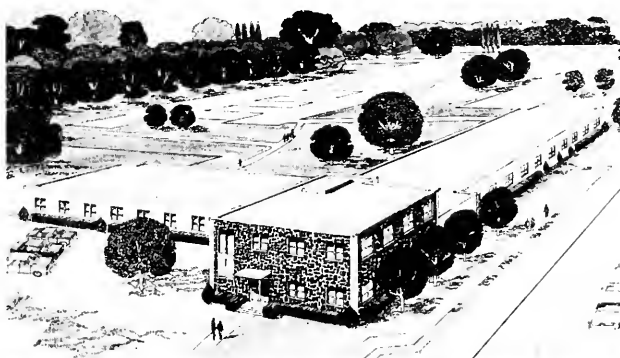
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Sets of four color lithographed copies, three of the University of Maryland Hospitals beginning with the Baltimore Infirmary founded in 1823 and one of the School of Medicine-Davidge Hall, are yet available. The proceeds from the sale of these prints will be used in the interest of the Davidge Hall project. Please complete the coupon and forward as soon as possible.

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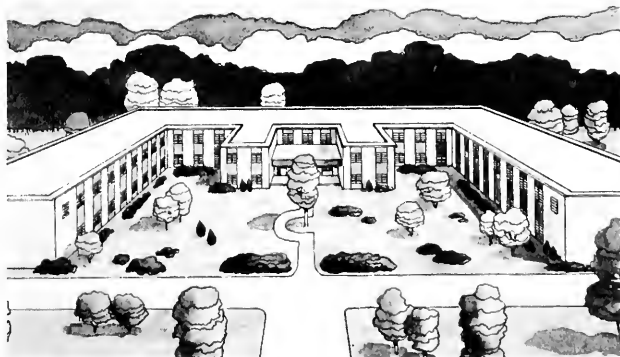
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# BULLETIN

university of maryland school of medicine



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October 15, 1977**

*Program*

12:00 noon	Buffet Luncheon
1:30 p.m.	<i>Greetings:</i> Dr. Stein <i>Introduction:</i> Dr. Dennis
1:45-3:15 p.m.	<i>Infectious Diseases: Recent Clinical Advances</i> Moderator: Dr. Kowalewski Speakers: Dr. Rapoport Dr. Hornick Questions and Answers
3:15-4:45 p.m.	<i>Trauma</i> Moderator: Dr. Jessee Speakers: Dr. Mason Dr. McLaughlin Questions and Answers

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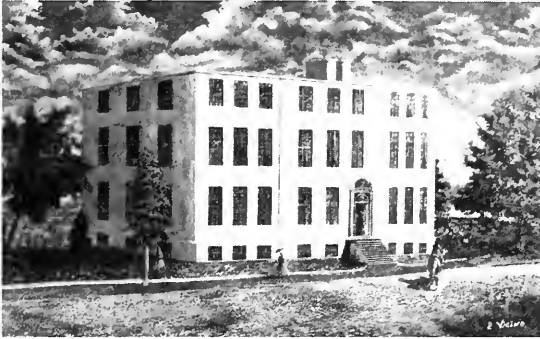
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# Epidemiologic Practice in the Community

Leonard Morse, M.D.

This is a report of my experiences, not of my experiments. My laboratory has been the community. For the past 15 years I have engaged in the practice of internal medicine with subspecialty interest in infectious diseases and clinical microbiology in Worcester, Massachusetts, a city inhabited by 176,000 in a county of 700,000. These experiences can be credited to my close relationship with the Worcester Health Department.

As examples of my experiences in infectious disease epidemiology, I have selected 7 events. All of these have been published.<sup>1-7</sup>

The first was a problem of vaccine-acquired paralytic poliomyelitis which occurred in an unvaccinated mother. The patient in her 30's acquired paralytic poliomyelitis 21 days after her three-month-old infant had received trivalent, live, oral polio vaccine. Type II poliovirus similar to the vaccine strain was isolated from the patient's stool and significant antibody to type II poliovirus was measured. This was the first case of documented, type II poliovirus infection occurring in a contact and the message was that all adults caring for infants who are immunized with live, oral polio virus should themselves be immunized.

The second event was an isolated case of typhoid fever occurring in an 18-year-old nurse assistant. The illness was due to phage type A *Salmonella typhi* and, because of nature's confinement of this illness to man, we set out to identify a previously unrecognized typhoid carrier in our community. Approximately 2 months earlier our patient began a new job in a nursing home. Confident that a carrier was responsible for this patient's illness, we cultured the stools of 120 residents of the nursing home and identified a patient excreting the same phage type *typhi*. The carrier was found to have cholelithiasis and was secreting 500 *S. typhi* per ml of bile obtained by biliary drainage.

The third event was an institutional outbreak of enteritis due to *Salmonella blockley*. Within a 7 day period approximately 10 cases of enteritis due to *S. blockley* occurred at the Worcester Memorial Hospital. Rectal swab cultures were promptly performed on all patients and hospital personnel (Figure 1); 167 individuals, many of whom were asymptomatic, were found to be infected. Except for members of the building and engineering departments, all groups working in the hospital were heavily infected. The incidence of infection was less among those em-

Fig. 1

<i>Salmonella blockley</i> Outbreak Worcester Memorial Hospital Distribution of Cases	
	No. Cases
Patients .....	43
Nurses .....	40
Dietary .....	40
Student Nurses .....	25
House Officers .....	10
Attending Physicians .....	4
Research .....	3
Building Engineering .....	2

Distribution of cases of *Salmonella blockley* among hospital population. Fewer cases observed in those groups who did not eat hospital prepared food.

ployees who carried their lunches and did not frequent the hospital cafeteria. Food and dietary surveys quickly recognized that the hospital prepared its own ice cream which was fortified with frozen, unpasteurized egg yolks. The egg yolks, packaged in 5 pound cans, were found to be heavily contaminated with multiple salmonella species. During the process of thawing bacterial multiplication in the periphery of the can occurred while the center core was the last to melt. The product then was used uncooked. Nearly everyone eats ice cream thus the wide distribution of this organism within the hospital family.

The fourth epidemiologic incident occurred recently and also involved salmonella. A 2-day-old infant, born vaginally, became ill with diarrhea, pneumonia, and probable sepsis. Stool cultures yielded *Salmonella bredeney*. Two other infants, born by Caesarean section, subsequently became ill with fever and diarrhea at 3 and 5 days of age and their stool cultures also grew *S. bredeney*. A fourth infant born at the same time was admitted at 7 days of age with a 3 day history of diarrhea. *S. bredeney* was isolated from his feces. All children were treated with parenteral ampicillin and recovered.

One hundred and four stool cultures from 14 other nursery patients, nursery personnel, laboratory technologists, and physicians were negative for enteric pathogens. Stool cultures, however, from 3 siblings and both parents, i.e., the entire family of the index case, were all positive for *S. bredeney*. Stool cultures from parents and siblings of the other in-

fectured infants were negative for enteric pathogens.

Since the mother of the index case was infected at the time of delivery, we theorize that the infant was delivered through an environment contaminated with *S. bredeney* and, during bathing and caring for other infants, transmission to the other infants occurred by the hands of nursing personnel. The outbreak was promptly recognized, contained and stopped by intensified, compulsive hand washing and hand degerming with a 96% isopropyl alcohol solution containing emollients. A thorough epidemiologic investigation of the infected family failed to reveal the source of their infection.

The fifth epidemiologic experience and the one I have found the most challenging was an outbreak of septicemia due to *Klebsiella pneumoniae* serotype 18 which occurred in the intensive care unit of St. Vincent Hospital in Worcester (Figure 2). Six pa-

Fig. 2

<i>Klebsiella Pneumoniae</i> (Serotype 18) Septicemia originating from a Hand-Cream Dispenser—I.C.U. S.V.H.—Data on Infected Patients					
		Primary	Adm. to	Venous	Onset of
Age	Sex	Diagnosis	I.C.U.	Catheter	Sepsis
8-74	M	Cardiac	30 Jan- 15 Feb	30 Jan- 15 Feb	15 Feb- 17 Feb
Culture					
Septicemia	Blood	Venous Cath.	Treatment		Recovery
5	5/6	5/6	Kanamycin Chloramphenicol		5/6

Data on infected patients; *Klebsiella pneumoniae* (Serotype 18) septicemia outbreak, St. Vincent Hospital.

tients in the unit, which had a capacity of 13, became septic during a seventy-two hour period. All were men with cardiac disease admitted during a two week period, all had venous catheters, and 5 of the 6 had positive blood cultures. The patient with a negative venous catheter culture and the one with a negative blood culture were not the same. Treatment varied according to the preference of each patient's physician and 5 of the 6 patients recovered. All bacterial isolates were serotype 18, and the obvious sources were eliminated. The outbreak occurred in the winter and, to counteract dry hands, nurses frequently used hand lotion after hand washing. Two decanter bottles were used and, from one, the offending organism was isolated in a concentration of 60,000 organisms per ml. The nurses in changing the dressings and "cleaning" the venous catheter sites daily inadvertently caused the infection by hand contamination.

The sixth was a sequel to this experience. Incorrectly assuming that contamination occurred as the result of frequent filling of the decanter bottles, we sampled hand lotion products direct from the manufacturer (Figure 3). Twenty per cent of all hand lotions direct from the manufacturer were found to be heavily contaminated with a wide variety of gram negative bacilli. Of the 5 brands summarized, 3 were used by 3 different hospitals in Worcester. Brand 3 contained 5 different species of gram negative bacilli in a concentration of 1.3 million bacteria per ml. At this hospital a bottle of lotion was distributed to each patient upon admission and was used for a variety of purposes from backrubs to body massage. We prepared large petri dishes using 22.5 cm and 27.5 cm Pyrex pie plates to demonstrate by hand impression the degree of bacteriologic

Fig. 3

Summary of Bacterial Isolates from Hand Lotions Unopened Bottles					
	Pos.	Total	Pct. Pos.	Avg. Conc. Per Ml.	Organism
Brand 1	9	13	70	130,000	<i>Serratia marcescens</i>
Brand 2	3	3	100	170,000	<i>Pseudomonas aeruginosa</i>
(Hosp. A)					
Brand 3	2	2	100	1,300,000	<i>Escherichia intermedia</i>
(Hosp. B)					<i>Klebsiella pneumoniae</i>
					<i>Alcaligenes faecalis</i>
					<i>Pseudomonas aeruginosa</i>
					<i>Enterobacter—Group C</i>
Brand 4	3	3	100	420,000	<i>Serratia marcescens</i>
(Hosp. C)					<i>Alcaligenes faecalis</i>
Brand 5	4	4	100	65,000	<i>Serratia marcescens</i>
					<i>Enterobacter—Group C</i>

Summary of bacterial isolates from 5 brands of hand lotion.

contamination with use of contaminated hand lotion. Figure 4 is a photograph of a hand after applying hand lotion made and distributed by a hospital in Worcester and contaminated by *Alcaligenes fecalis* and *Enterobacter aerogenes*. Figure 5 is a photograph of a hand after the application of a nationally distributed hand lotion heavily contaminated with *Pseudomonas aeruginosa*. The contamination was so great that the colonies were confluent.

The last epidemiologic event was an outbreak of infectious hepatitis due to Hepatitis A virus involving

the Holy Cross College football team. The college is constructed on the side of a hill; the top of the campus where exposure occurred is over 200 feet higher than the base. The water pressure was significantly lower (40 psi) at the top of the hill where practice football fields are located than at the foot of the hill where the water pressure was 140 psi. Ninety members of the 97 membered team were infected (Figure 6). Fifty-four were symptomatic and became ill dur-

Fig. 6

Infectious Hepatitis—Holy Cross College  
Classification of Illness

Icteric .....	32
Anicteric Symptomatic .....	22
(Specific Onset Date)	
Asymptomatic .....	36
(SGPT Greater than 100)	
No Disease .....	7
TOTAL:	97

Classification of illness, infectious hepatitis, Holy Cross College football team.

ing a two week period (Figure 7). The remaining 36 patients had significantly elevated liver enzymes when the entire team was bled at the height of the outbreak. The infection was the result of an imperfect water supply at the football practice field. Underground irrigation faucets interrupted the potable water supply and served as cross connections (Figure 8). Neighborhood children ill with infectious hepatitis played in the field and frequently left the water running allowing water to pool around the subsurface irrigation faucets. A lowering of water

Dates of onset of illness of symptomatic patients, infectious hepatitis, Holy Cross College football team.

INFECTIOUS HEPATITIS  
HOLY CROSS COLLEGE

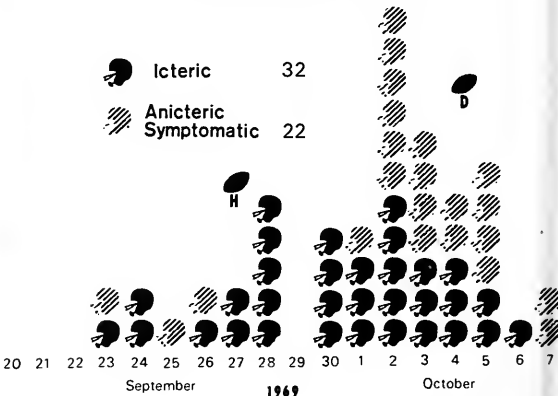
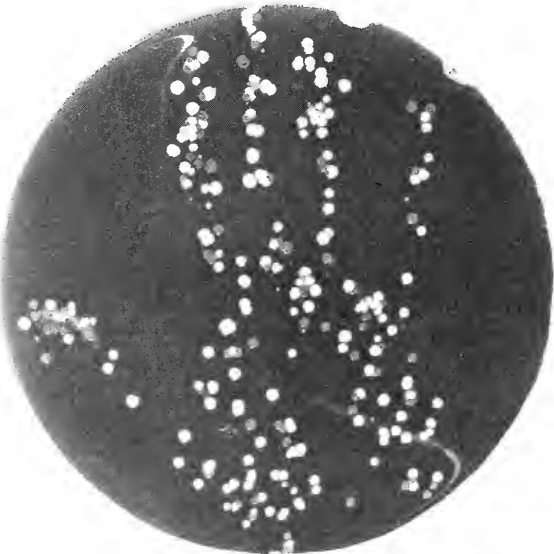


Fig. 7

Fig. 4



Hand impression on a large blood agar plate after conventional application of a contaminated hand lotion; white and grey colonies represent 2 different Gram-negative bacilli, *Alcaligenes fecalis* and *Enterobacter aerogenes*.

Fig. 5



Hand impression on a large blood agar plate after conventional application of hand lotion contaminated with *Pseudomonas aeruginosa*.

Fig. 8



An underground partially submerged irrigation faucet on the practice football field, Holy Cross College.

pressure would result in syphonage into the system. Examination of fire department records confirmed a 2 alarm fire occurring at a location proximal to the field exactly five weeks before the onset of the outbreak. The water pressure at night was 40 psi and opening a fire hydrant proximal to the field created a precipitous fall in the water pressure to negative levels.

Thus, during a high prevalence period of infectious hepatitis, infected children were attracted to an imperfect water system in the heat of autumn. The additional links in the chain of events responsible for this unusual outbreak were a 2 alarm fire and a thirsty football team.

These experiences can be credited to establishing a close relationship with the Worcester Health Department and serve as an example of epidemiology at a community level. My medical training was devoid of significant public health exposure. In preparation for this presentation I reviewed a sample of medical school catalogs and suspect that, perhaps, with exception of those medical schools with allied schools of public health, medical students have little opportunity to be stimulated by public health. Medical school curricula should include exposure to health department activities; prevention of illness, disease detection, and health preservation are the challenges of today.

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Ed. Note: Leonard J. Morse, Class of 1955 of the University of Maryland School of Medicine, is a practicing internist in Worcester, Massachusetts; medical epidemiologist, Worcester Health Department and Assistant Professor of Medicine at the University of Massachusetts Medical School.

Ed. Note: Portions of the article, presented at the Bicentennial Celebration of the University of Maryland School of Medicine, also were presented before the American Public Health Association on November 20, 1975 and at the Infectious Disease Society of Sweden on September 7, 1976.

# How Lack of Medical Knowledge Once Saved Baltimore

Walter Lord

In this Bicentennial celebration, as we bask in the pride that rightly goes with so many years of medical progress and achievement, I hate to sound a jarring note, but there once was a time when Baltimore was saved by *lack* of medical knowledge. As a somewhat mischievous layman, cast in the midst of this distinguished professional gathering, I thought I might remind you of it—although, of course, it probably means I'll never receive another house call from a doctor.

It all began on August 30, 1814 at the little town of Benedict, Maryland, on the Patuxent River, about 50 miles south of here. In the boldest stroke yet in what we now call the War of 1812 a small British army of 5,000 men had just captured Washington, burned the public buildings, and was reboarding its transports in triumph. The Vice Admiral in charge of the expedition, Sir Alexander Cochrane; his task force commander, Rear Admiral George Cockburn; and the troop commander, Major General Robert Ross, were all in high spirits. Their only problem was where to go next.

Admiral Cockburn, a free-wheeling fighter stamped from the same mold as George Patton, felt he knew exactly what to do: attack and burn Baltimore immediately. Baltimore was the third largest city in America, a hot-bed of pro-war enthusiasm, and the home port of over 100 privateers ravaging British commerce. It was reported to be full of loot, and at the moment lay ripe for the taking. The American army was scattered; the city's defences were weak, and the citizens were in a state of panic. The British had the momentum, and victory would be easy.

General Ross was inclined to agree.

Admiral Cochrane, the commander-in-chief, wasted no love for Baltimore either. He thought it was a nest of pirates that "ought to be laid in ashes." But not just yet. No matter how weak and demoralized the city's defenders might be, he knew that another far tougher, far more deadly enemy might strike at any moment. This was a mysterious fever that seemed to erupt in the Bay area at this time of year.

No one knew the cause, or how it spread, but it took a fearful toll—particularly among those not used to the hot, humid climate of the Chesapeake.

Since it usually occurred between mid-August and the end of September, some suggested it had something to do with the equinox. Others, noting that it was especially prevalent in swampy, low-lying areas, felt that the fever resulted from a combination of noxious vapors rising from the swamps and the atmosphere at this time of year.

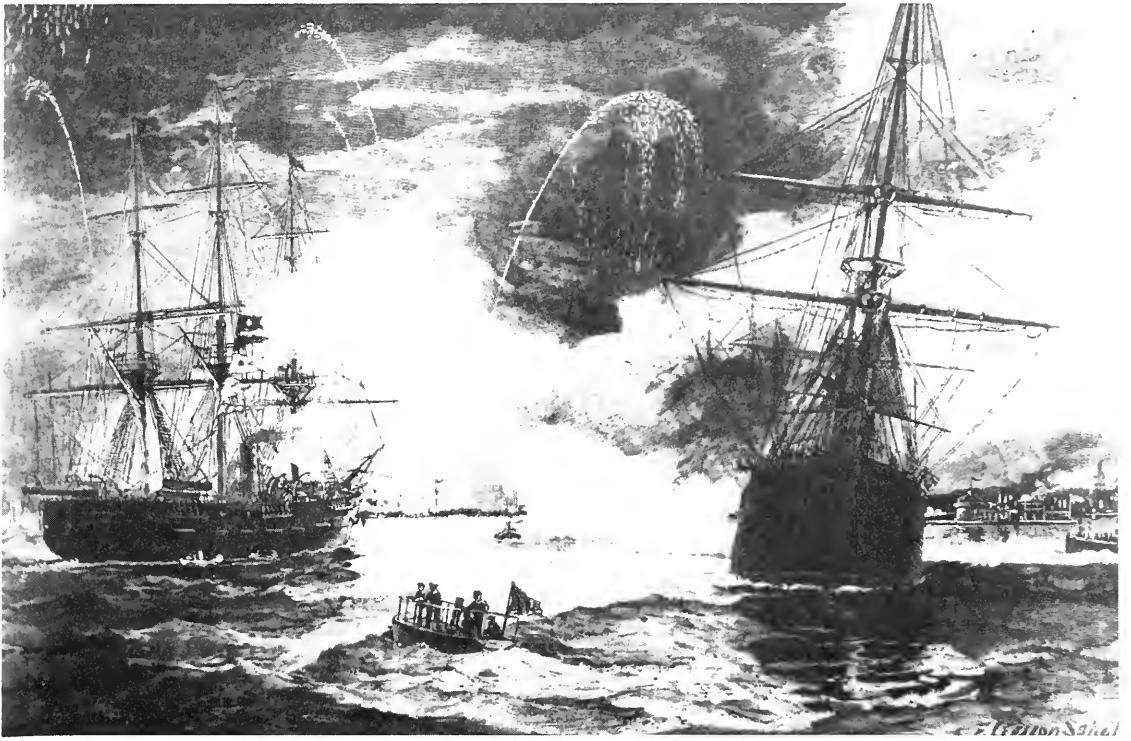
Whatever the explanation, Admiral Cochrane was sure that the Bay was no place to be during the "sickly season" as he called it. The British experience in the Chesapeake the previous year, 1813, showed what could happen. The commander at that time, Admiral John Borlase Warren, had around 2,000 men on hand at the beginning of August. By the first of September some 500-600 were out of action—either sick or dead—from what Cochrane called "fevers and ague." The loss of so many men—more than a quarter of the force—ended the campaign, and in desperation Warren returned to Halifax to save the rest.

Cochrane had Warren's experience very much in mind from the moment he took command of a new and much larger British force assembled at Bermuda in July 1814. One of his first decisions was to avoid any operations in the Chesapeake during the "sickly season." Writing the Secretary for War & the Colonies, Earl Bathurst, on July 23, he explained that he would confine his activities to the northern states until October, then come down and go to work in the Bay.

A few days later, however, an enthusiastic letter arrived from Admiral Cockburn, who was already in the Chesapeake with an advance force. He was so optimistic about the opportunities of a campaign there—particularly a dash on Washington—that Cochrane reversed himself and went for the Chesapeake and Washington despite his fears.

It had all worked out, but always in the back of his mind was his fear of the "sickly season." Now that his troops were back on the transports safe and sound, he didn't want to stretch his luck any further. He would shift operations to Rhode Island, where it was cool, and not return to the Chesapeake until November. General Ross was easily persuaded, and there was nothing that Cockburn could do but go along with the commander-in-chief.

As the fleet headed back down the Patuxent on



September 2, Cochrane wrote a letter to Earl Bathurst explaining his decision: "The worst enemy we have to contend with is the climate. This obliged us to proceed to the northward . . . By the beginning of November we will be leaving Rhode Island and pointing toward this quarter again."

On September 3 he elaborated in a letter to Viscount Melville, the First Lord of the Admiralty: "As September is a fatal month even for the inhabitants of Virginia and more so for strangers, I mean to proceed to the northward and if possible try to surprise Rhode Island . . . About the close of October we will move to the southward and act agreeably to the information we may receive . . . I propose an attack upon Baltimore, the most democratic town and, I believe, the richest in the Union."

Most of the staff were convinced he was right. Fear of the unknown can play tricks with one's imagination, and Cochrane's Fleet Captain, Edward Codrington, fancied he already saw signs of the mysterious fever everywhere he looked. On the 5th he wrote his wife: "The sickly season here is about at its height, and from the uncommonly cadaverous appearance of the natives who are in health, the country with all its beauty of scenery is not fit for the habitation of social man."

Early on the morning of September 7 the British fleet lay ten miles south of the Potomac, preparing to separate on various assignments, with the bulk of it heading north toward Rhode Island in accordance

with the commander's orders. Then, unexpectedly, new information arrived about the weakness of Baltimore. The exact source isn't clear even today, but I think it was the frigate *Menelaus*, sent up the Bay on a sort of diversion during the march on Washington. Off the Patapsco the Captain of the *Menelaus* sent a tender up the river to test Baltimore's defences, and found them in a shambles. The tender even captured a boatload of fruit in the shadow of Fort McHenry.

Fever or no fever, this was too good to miss, and once again Admiral Cochrane reversed himself. He decided to head for Baltimore. New orders went out to all hands, including Admiral Cockburn, who was naturally delighted.

But it was now September 7 and the fleet was far down the Bay. Moreover, two more days were lost while Cochrane waited for a separate squadron that had gone up the Potomac to raid Alexandria. He finally reached North Point about 1:30 p.m. on Sunday, September 11—at least a week, and possibly nine days, later than if he had followed Cockburn's advice instead of yielding to his fear of the "sickly season."

What had happened in Baltimore during that week? A very great deal. Under the dynamic direction of Major General Sam Smith a line of fortifications had been dug along the eastern edge of the city (about where Patterson Park is now). Over 16,000 troops manned the entrenchments. A line of barges, armed with cannon, stretched from Fort McHenry to

Lazaretto Point. Block ships were assembled, ready to be sunk in the channel. Fort McHenry itself bristled with 57 guns, backed by more than 1,000 men. True, some of this work had been started as early as August 28, but the difference between six days to get ready and 15 days to get ready was all the difference in the world.

Even more important was the difference in spirit. On August 25 a Baltimorean named David Winchester had written a relative in Tennessee, "You may be sure this is the most awful moment of my life. Not because, if the place is defended, I shall put my life at hazard in common with my fellow citizens, but because I am positively sure we shall not succeed." By September 9 Sam Smith had done so much that the city's problem was not defeatism but overconfidence. Writing a friend in Philadelphia, Commodore John Rogers remarked that Baltimore "now has nothing to fear even should the enemy make his appearance tomorrow."

Not "tomorrow" but the day after tomorrow was to be the test. We all know the results. For two days and three nights Admiral Cochrane threw everything he had at Baltimore, but Sam Smith had used his week of grace well. Finally, in "the dawn's early light" of September 14, the British fleet withdrew and on the 15th reembarked the troops at North Point.

All the 16th the fleet lay anchored off the Patapsco, while Baltimore could hardly believe it was over. After all, the British had suffered little damage and relatively few casualties. True, General Ross had been killed by a sharp-shooter's bullet, but the swashbuckling Cockburn was still very much alive. Would they try again?

Not a chance. Admiral Cochrane had embarked on this operation against all his better instincts. Now he was determined to conserve his forces for a long-cherished attack on New Orleans after the cool weather set in. Meanwhile he wanted no more of Baltimore and no more of the "sickly season." On the 17th he headed back down the Bay, and our city's ordeal was over.

What was this "sickly season" that raised such havoc with Cochrane's timing . . . that caused this mysterious fever that he considered "the worst enemy we have to contend with?"

Cochrane didn't know . . . the Baltimoreans didn't know . . . nobody knew. It was almost certainly yellow fever, and it took nearly 100 years more, before medical knowledge reached a point where we realized that it was carried by the lowly mosquito. It was 100 years of slow, steady progress, 100 years in which at least two alumni of this institution—Henry Rose Carter and James Carroll—played a distinguished part.

Thanks to their dedicated work, and that of others, yellow fever was finally conquered, and the mosquito put back in its place.

If this knowledge had come a century earlier—if in 1814 the proper control measures had been known and followed—there would have been no "sickly season" for Admiral Cochrane to fear, and there's no reason why he would have hesitated to attack Baltimore while it was weak and demoralized. But happily, thanks to lack of medical knowledge, Baltimore enjoyed its week of grace; the city was saved; Davidge Hall was not laid in ashes; and today we can celebrate our nation's Bicentennial in this elegant and splendid setting.

Ed. Note: Walter Lord is a native of Baltimore, now living in New York City. As the author of many popular historical books, among them, "A Night to Remember" and "The Dawn's Early Light," he has appeared often on the best seller lists. This BULLETIN article was presented by Mr. Lord at the Bicentennial Celebration held by the University of Maryland School of Medicine on December 6, 1976.

Mr. Lord's article is illustrated by an engraving from Harper's Weekly of September 21, 1889 in which the artist, F. Cresson Schell, has depicted the sham naval battle that enacted the bombardment of Ft. McHenry. This engraving was obtained through the courtesy of the Enoch Pratt Library of Baltimore.

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# Seven Steps to CME Success:

## II. ASSESSING YOUR PRACTICE\*

William F. Jessee, M.D.

In developing an effective personal program for continuing medical education (CME), a systematic approach can pay tremendous dividends. In the February issue of the *Bulletin*, we delineated seven essential steps in a personal learning plan for maintaining professional excellence (1). Those seven essentials are:

1. Determine your needs
2. Assess your practice
3. Select specific learning objectives
4. Decide how to achieve each objective
5. Inventory available learning resources
6. Decide on priorities and establish a schedule
7. Evaluate your learning achievement

This article is the second in a series which will examine each step in detail.

Since the ultimate purpose of CME is to improve patient care, the particular configuration of your practice offers an important determinant of your personal learning needs. Logically, such an assessment is part of the first step; however, we have separated it out because it is such a large task in itself.

Practice assessment involves three parts: firstly, a picture of the *total range* of disease entities and patient problems you see; secondly, the *frequency* of the various entities; thirdly, a judgment as to which of these health problems requires your *highest competence*, e.g., a pediatrician might see very few cases of congenital heart disease in infants, but, when one arises, it is clearly a crucial matter.

The net result will be a personal practice profile which can offer you detailed insight into your particular mix of patients and, thus, your continuing education needs. Lest you think this a pointless exercise, consider this finding from a study of 37 Wisconsin physicians: the profile of diseases seen by various physicians varied widely, even among primary-care physicians in the same town or area. The practice profile, then, is a highly individualized indicator of those areas in which your CME time can be used most profitably.

The sample worksheets below offer the simplest way to get systematic data on the shape of your practice. You might wish to complete these forms yourself or you can train your nurse or receptionist

to keep the record for you. If your practice is hospital-based or in a good-sized clinic, you might be able to take advantage of the problem-oriented record and a computerized record system. The best-known system is the PAS (Professional Activity Study) and MAP (Medical Audit Program) offered by the Commission on Professional & Hospital Activities (1968 Green Road, Ann Arbor, Michigan 48105). In addition to other computer print-out summaries, this service provides a periodic print-out on your patients that lets you compare your practice procedures over time. Some large hospitals and clinics have now developed in-house computer systems with similar capabilities.

### Worksheet Part 1

A separate worksheet should be completed for each of four days that you will select as a sample of your practice. You might spread it over a month—Monday of the first week, Tuesday of the second week, Thursday of the third (or Wednesday, if your usual day off is Thursday), and Friday of the fourth week. An obvious alternative is a sample of past records, e.g., all patients seen on Monday during the past month, or patients seen on the second Wednesday of last January, April, July, and November.

For each day chosen for your sample, record the information for all patients seen from midnight to midnight. If a diagnosis or probable diagnosis cannot be made, ignore the last column. If the visit is not made for an illness, e.g., immunization, specify in the "Reason for Visit" column and ignore the last column. Estimate age if not known. In the last column list *all* diagnoses for each patient.

If yours is a highly-specialized practice, e.g., ophthalmology, you might find it most efficient to ignore Part I and have your nurse or secretary summarize the information needed on Part II.

### Worksheet Part 2

From the Part I Worksheets, summarize the information by categories relevant to your practice, to produce a personal practice profile. Depending on your practice, these categories might be broad or narrow; primary-care physicians will find useful several of the categories below (adapted from the University of Wisconsin Individual Physician Profile program, which in turn adapted them from ICDA, International Classification of Diseases Adapted for Use in the United States).

\*This article is based on a publication entitled, "Your Personal Learning Plan: A Handbook for Physicians," by Leonard S. Stein, published by the Illinois Council on Continuing Medical Education, 360 North Michigan Avenue, Chicago, Illinois 60601.

**WORKSHEET    PART I:** Daily Patient Log for \_\_\_\_\_, 19\_\_\_\_  
DATE

PATIENT			WHERE SEEN	REASON(S) FOR PATIENT CONTACT	
#	Age	Sex	Office .....O Hospital .....H Home .....HM Elsewhere .....E	Symptoms (if Diagnosis Not Yet Made), OR Reason for Visit	ALL Diagnoses for Patient

**WORKSHEET    PART II:** Summary of Patients Seen—PRACTICE PROFILE

REASONS FOR VISIT, DIAGNOSES (probable or established)	Number	REASONS FOR VISIT, DIAGNOSES (probable or established)	Number
Now, check your final entries on Worksheet A again, making changes on the basis of insights gained from this patient review. You may add or delete items; or you may change the priority or der; or you may only confirm that in fact you understand your needs very well indeed, in terms of your Practice Profile.			

- I. INFECTIVE & PARASITIC DISEASES

II. NEOPLASMS  
Malignant neoplasms not of blood  
Neoplasms of blood & lymphatics  
Benign neoplasms

III. ENDOCRINE, NUTRITIONAL, & METABOLIC DISEASES  
Diabetes  
Obesity  
Other endocrine, metabolic, &  
nutritional diseases

IV. DISEASES OF THE BLOOD & BLOOD FORMING ORGANS

V. MENTAL DISORDERS  
Social problems

VI. DISEASES OF THE NERVOUS SYSTEM & SENSE ORGANS  
Central nervous system  
Eye & ear

VII. DISEASES OF THE CIRCULATORY SYSTEM  
Rheumatic fever & heart disease  
Hypertension  
Ischemic heart disease  
Other heart diseases  
Cerebrovascular disease

- Other vascular diseases
- Cardiovascular unspecified
- VIII. DISEASES OF THE RESPIRATORY SYSTEM
  - Acute respiratory infections
  - Bronchitis, emphysema, asthma
  - Other respiratory diseases
  - Respiratory system unspecified
- XI. DISEASES OF THE DIGESTIVE SYSTEM
  - Oral cavity, salivary glands, jaws
  - Esophagus, stomach, & duodenum
  - Intestine & peritoneum
  - Liver, gallbladder, & pancreas
- X. DISEASES OF THE GENITOURINARY SYSTEM
  - Urinary system
  - Male genital organs
  - Breast & female genital organs
- XI. DELIVERY AND COMPLICATIONS OF PREGNANCY, CHILD BIRTH, & THE PUERPERIUM
  - Complication of pregnancy & puerperium
  - Delivery
  - Pre-natal examination
  - Post-partum
  - Contraception
- XII. DISEASES OF THE SKIN & SUBCUTANEOUS TISSUE
- XIII. DISEASES OF THE MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE
  - Arthritis & rheumatism
  - Muscular-skeletal system, connective tissue
- XIV. CONGENITAL ANOMALIES
- XV. NEWBORN INFANTS
  - Perinatal morbidity & mortality
  - Well baby & child care
  - Other diseases peculiar to the newborn
- XVI. SYMPTOMS & ILL-DEFINED CONDITIONS
- XVII. INJURIES & ADVERSE EFFECTS
  - Fractures, dislocations, sprains, strains
  - Other trauma including burns
  - Adverse drug effects & poisoning
  - Other adverse effects
- XVIII. OTHER
  - General examination
  - Radiological examination
  - Other examinations without illness
  - Post-operative care & rehabilitation
  - Practice management
  - Sports medicine
  - Preventive medicine
  - Geriatric problems
  - Adolescent medicine

Next month, we will examine the use of this profile in selecting specific learning objectives. In the meantime, to learn how one physician in specialty practice makes use of an ongoing practice profile for his own education, a recent article by Cassel in the *Journal of the American Medical Association* is recommended reading (2).

#### Reference

1. Jessee, W. F., Continuing education: Are You Satisfied, *Bulletin of the University of Maryland School of Medicine*, 62 (1):13-14, 1977.
2. Cassel, C: "A Diagnostic Index of Clinical Practice", *JAMA*, 237: 663-667, 1977.

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# Accountability in Health Care

G. Bruce McFadden

In the United States, access to medical care as well as the quality of that care has improved greatly in the last decade as evidenced by the following:

- Death rates have been falling for the last seven years when adjusted for the aging population. Between 1968 and 1975 the fourteen percent decrease in death rates was as high as any seen during this century.
- From 1970 to 1975 infant mortality rates fell more than nineteen percent from 20 to 16.1 per 1,000 live births.
- Maternal mortality dropped fifty percent from 21.5 to 10.8 per 100,000 live births between 1970 and 1975.
- From 1968 to 1975, death rates from coronary heart disease decreased by eighteen percent.<sup>1</sup>

However, the United States has spent more for health and medical care during the last ten years than it did during the previous thirty-five years. An average hospital stay cost \$311 in 1965 and \$1,017 in 1975. An average family's outlay for health care rose from \$567 in 1960 to \$2,188 in 1975. In 1976, health care consumed 8.3 percent of the gross national product and at the current rate of increase can be expected to consume 10 percent by 1980. Both the public and the government realize these increases cannot continue for either the individual or the society without seriously jeopardizing the current economic order and the competition for finite resources.

The health care industry is increasingly being called upon to be accountable for allocated resources. The seemingly endless, and possibly irresponsible, supply of resources that was available in the sixties is giving way to an era that is rapidly becoming one of extreme austerity. Consumer outcries have spurred government at all levels to demand

cost containment within the health care industry. Hospitals, as the largest consumer of health care dollars, are feeling the brunt of this cost containment thrust. At the same time, consumers, government officials and health care practitioners are demanding that the latest and most sophisticated medical advances be available for themselves, their constituents and their patients. Essentially, hospitals, their medical staffs and their support staffs are being called upon to do more and more with less and less.

Recent legislative initiatives have been aimed at tighter regulation of hospital costs. If the health care industry does not take aggressive steps to stem this trend of rising costs, the Government can be expected to enact broader and more restrictive legislation in this area. Should this come to pass, the private practice of medicine may well see similar regulation. Recent government action certainly indicates that, if the health care industry does not curb its costs voluntarily in the near future, the Government will do it. The choice will not be ours much longer.

Many individuals in the Hospital have control of resources and can practice cost containment. It is often said that physicians' decisions are the key to cost containment because the physicians determine most of the utilization of health care services. Analyses of the rising cost of health care have revealed wide variations in utilization and delivery practices, particularly admission rates, surgical rates, lengths of stay and diagnostic regimens. These differences do not seem justified on any basis demonstrable by variation in outcome, morbidity or mortality. As a teaching institution and medical leader in the community and the State, the University of Maryland Hospital has a responsibility for teaching and demonstrating in practice appropriate, yet prudent, use of its limited resources. Cost containment is the responsibility of everyone who impacts on the use of available resources in the Hospital.

<sup>1</sup> *Annual Report*, Robert Wood Johnson Foundation, 1976.

Ed. Note: Mr. G. Bruce McFadden is Director of the University of Maryland Hospital.

# PRESIDENT'S MESSAGE

Herbert J. Levickas, M.D.

It is with pride I assume the presidency of the Medical Alumni Association. I am proud of this expression of confidence in me and it is my sincere desire to meet your expectations.

A momentum and enthusiasm has been present within our Association in recent years. Our membership has increased to 5,000 allowing us to make a maximum effort in our commitments to the Medical School, Dean, faculty and Davidge Hall. The increase in activity this past year has come through the tireless work of our past presidents, the Dean, Board of Directors, and various committees. The staff of the Association, directed by Mrs. Jean Goral, our Executive Administrator, has been very supportive.

At this time, I would like to acknowledge Dr. James A. Roberts for his outstanding leadership and efforts during the past year. Many constructive changes have been made with his guidance and the assistance of the Board of Directors.

Our annual Alumni reunion, this past June, was the most successful we have had in recent years. The attendance at the reunion activities greatly surpassed previous years, indicating continued and increased interest in our school and Association. All of the honorary, business, social, rededication, and commencement functions were well received. The 50-year graduates and the recent graduates were honored at the annual banquet as well as Dr. John Z. Bowers, class of 1938, who was designated recipient of the Honor Award and Gold Key as the outstanding alumnus making extensive contributions to the art and science of medicine.

As mentioned previously, many significant changes have been made this past year to increase the responsibilities and involvement of the alumni. Your continued financial support in payment of dues is necessary for maintaining a vigorous, progressive organization.

Briefly, I would like to outline the changes which have taken place and convey the most important project in which the Association is involved.

Our commitment to the restoration of Davidge Hall will be given in a separate report by the Davidge Hall Committee headed by Dr. John A. Wagner. An architectural report has been rendered by Architectural Conservators, Ltd. and Cochrane, Stephenson and Donkervoet, Inc. Priorities for restoration will be established and continued fund raising will be carried out.



With increasing activity and creation of full time responsibilities in the alumni office, Mr. James A. Allen has been appointed as Executive Director. Mr. Allen is a knowledgeable and responsible individual who comes to us from Kean College of New Jersey. He will head the alumni staff but focus his attention in the areas of development and public relations. Mrs. Jean D. Goral will serve as Assistant Director. An introductory profile is found in this *Bulletin* and you will become more aware of his presence when he assumes his duties.

With the continued streamlining of our organization, it was decided at the last business meeting in June that the Association become incorporated. After deliberation by the Board of Directors and advice from legal counsel, this action was presented to and approved by the membership. It is fact that the identity of our association would be enhanced by this action, but foremost, the liabilities of our officers and members would decrease. The legalities involved should be accomplished by the time this *Bulletin* is distributed. Appropriate Constitution and Bylaw changes have been made to accommodate incorporation.

Student financial aid is another area in which the association has increased activity. Through a large bequest from the estate of Dr. Walter M. Winters of New Jersey, our Association will be able to assist worthy and needy second, third and fourth year medical students. These resources will become available upon receipt of the total bequest sometime this year.

On behalf of the Board of Directors, I wish to commend Dr. George H. Yeager, who not only assumes the responsibility of the editorship of this publication, but for the tremendous amount of time and effort expended in establishing a Museum, rearranging portraits, anatomical drawings, etc. for a most effective display for the Reunion.

Our initial social function will take place on October 28, 1977 at Hunt Valley Inn. This function will be the Annual Oyster Roast honoring our third year medical students. It is a pleasant event which has been well attended for the past three years, and we invite you to come. A detailed announcement will be mailed several weeks prior to the event.

Plans are big for the Southern Medical Association

meeting in Dallas, Texas on November 6 and 7. Information on this event will be forwarded to all alumni in the states representing the southern region.

By means of this communication, the Board of Directors and I ask for your support. The alumni office will be grateful for any suggestions, inquiries or criticisms.

---

## EXECUTIVE DIRECTOR APPOINTED

The Board of Directors is pleased to announce the appointment of Mr. James H. Allen as Executive Director of the Medical Alumni Association effective July 1.

Mr. Allen, or Jim as he prefers to be addressed, comes to the Association from Kean College of New Jersey, one of New Jersey's eight State Colleges, where he served as Director of Alumni Affairs for the past four years. During that period, Jim increased alumni donations to Kean College threefold while also expanding programs and services for an alumni body of 16,000.

Prior to his work at Kean College, Jim spent a year and a half at his alma mater, the University of Massachusetts, as an alumni program planner. This was followed by two years at Western New England College, a small liberal arts college in Springfield, Massachusetts, as Director of Alumni Affairs. In the latter position, he was given the tasks of developing an alumni program and establishing an alumni annual giving campaign.

Mrs. Jean D. Goral, who has acted as Executive Administrator of the Association for the past three years, will assume the title of Assistant Director.

The seven years' experience Jim brings to the Medical Alumni Association will provide a new professional dimension to the organization, particularly



in fund raising and alumni programming. This expertise, along with Mrs. Goral's background and an efficient office force, composed of Sheila A. McNair (Clerical Assistant), Patricia E. Miller (Secretary) and Ruth S. Caldwell (part-time secretary), will provide the Association with a strong staff to service alumni in years ahead.

# 1977 ALUMNI REUNION

The registration of Alumni during June 1 and 2 was the largest since 1970. Alumni were present not only from the surrounding states, the east, north and south, but some attended from distant states such as Utah, Texas and California.

On the evening of Wednesday, June 1, despite threatening weather, approximately 225 alumni, guests, and faculty members attended the Cocktail Reception held in the gardens and Chemical Hall of Davidge Hall.

Thursday, June 2, began with registration, followed by Opening Exercises conducted by the President, Dr. James A. Roberts, at which time Dr. Albin O. Kuhn, Chancellor of the University of Maryland at Baltimore, and Dr. John M. Dennis, Vice Chancellor for Health Affairs and Dean, School of Medicine, apprised the progress and future plans of the Baltimore Campus and the advancements made by the School of Medicine.

Prior to the Annual Business Meeting, 31 members of the Class of 1952 received individually engraved certificates recognizing their 25 years of service to medicine.

The meeting was called to order by Dr. Roberts; the minutes of the meeting of June 3, 1976 were approved as distributed; Dr. William H. Triplett, Past President and Executive Director, delivered an inspirational message in memory of deceased Alumni.

The officers and members of the Board of Directors elected were:

*President:*

Herbert J. Levickas, M.D., '46

*President-elect:*

Robert T. Singleton, M.D., '53

*Vice Presidents:*

Benjamin M. Stein, M.D., '35

Harold L. Daly, M.D., '50

Andrew J. Devlin, M.D., '52

*Secretary:*

William J. R. Dunseath, M.D., '59

*Treasurer:*

John F. Strahan, M.D. '49

*Members of the Board:*

(Three-year Term)

Joseph D'Antonio, M.D., '46

Isadore Tuerk, M.D., '34

Nathan Schnaper, M.D., '49

The following members were elected to serve on the Nominating Committee (with the immediate two past presidents): Julian W. Reed, M.D. and Morton M. Krieger, M.D., Class of 1952 and Patrick C. Phelan, M.D., Class of 1942.

Other items on the agenda included the adoption of the Articles of Incorporation, a financial report of the Association, Davidge Hall report and the announcement of the 1977 Honor Award and Gold Key recipient.

Following the introduction of the President for 1977-78, Herbert J. Levickas, M.D., the meeting was adjourned.

The report of the Rededication of Davidge Hall which followed the meeting is detailed on page 22.

Dr. John M. Dennis conducted a tour of the School of Medicine prior to a buffet luncheon served in the Terrace Room of the Student Union Building.

The Annual Banquet, which was held on Thursday evening, began with a reception, followed by the dinner. Members of the 1927 Class were escorted to their designated tables by members of the Class of 1977.

Following dinner and the introduction of the head table, Dr. Roberts presented the Honor Award and Gold Key to John Z. Bowers, M.D., Class of 1938. Dr. Bowers graciously accepted the award.

As Dr. Roberts gave a brief biographical sketch of each of the 29 members of the Class of 1927 present, Dr. Garry Ruben, President of the Class of 1977, presented the 50-year certificates.

Dr. Ruben expressed his appreciation on behalf of his class for the invitation to the banquet.

With the acknowledgement of classes celebrating five-year reunions and honored guests, the program concluded and was followed by dancing.

Jean D. Goral

*Assistant Director*

Medical Alumni Association

## JR. OYSTER ROAST OCTOBER 28, 1977

Hunt Valley Inn

Mark your calendars for the annual roast held in honor of the Jr. Class. Watch for announcement in the mail. *Make your reservations early!*

## SOUTHERN MEDICAL

Members of the SOUTHERN MEDICAL ASSOCIATION . . . see you in Dallas in November.

The Presidential Suite will be open during 3:00-5:00 p.m. on Sunday, November 6, and 5:00-7:00 p.m. on Monday, November 7, 1977.

Stop at the Medical Alumni Association Registration Desk to obtain room number of Presidential Suite.



1. Looking down from the top of Chemical Hall

## 1977 ALUMNI COCKTAIL RECEPTION



2. Dr. Herbert J. Levickas, '46, Mrs. Allen, Mr. James H. Allen, Executive Director.



3. Susan Strahan, '79, Stephen Mosberg, '79, volunteer student guides.



4. Dr. Bernard Karpers, '62, Co-Chairman of Alumni Day; Mrs. Karpers; Dr. W. H. Mitchell, '47; Mrs. Mitchell.



5. L-R Bottom: Mrs. Lapinsky, Ms. Marian McPherson, Dr. Vernon Smith, Second Row: Richard Lapinsky, '78, Mrs. Vicki Lapinsky, Dr. Herbert Lapinsky, '39, Back: Peter Lapinsky, '80.

6. L-R: Dr. Marvin Cornblath, Dr. George H. Yeager, '29, Dr. Wade Garner, '27.





# DAVIDGE HALL GARDEN

7. The Japanese lanterns and blooming rose bushes added a bright touch to the festivities.



8. L-R Bottom: Dr. Wallace H. Mitchell, '47, Mrs. Mitchell, Mrs. Hall, Dr. Howard Hall, '47, Dr. Jose G. Valderas, '47, Back: Dr. Eugene P. Salvati, '47, Mrs. Salvati



10. Mrs. Triplet, Dr. William Triplet, '11, Dr. Thomas B. Connor, '46



12. L-R: Dr. Elton Resnick, '37, Mrs. Resnick, Mrs. Frank Greenwald, Dr. Frank Greenwald, '37, Back Row; Mrs. Spielman, Dr. Morton M. Spielman, '37, Dr. Wade Garner, '27.



9. L-R: Dr. John Rogers, '67, Mrs. Rogers, Dr. Gordon Earles, '67, Mrs. Earles

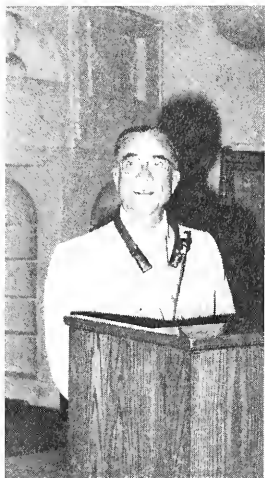


11. L-R: Dr. George Morningstar, '55, Mrs. Morningstar, Dr. George R. Baumgardner, '58, Mrs. Mullan, Dr. Paul A. Mullan, '57



13. L-R: Mary Anne Lantz, Dr. Merrill J. Snyder, Mrs. Snyder, Standing: Dr. James R. Karns, '40, Dr. David Geddes, '47.

# BUSINESS MEETING AND REDEDICATION



14. Albin O. Kuhn, Ph.D., Chancellor of the Baltimore Campus



15. Herbert J. Levickas, '46, President and James A. Roberts, '46, Past President



16. Dr. Byruth Lambros, '27, Mrs. Jean D. Goral, Assistant Director.



17. Rededication of Davidge Hall



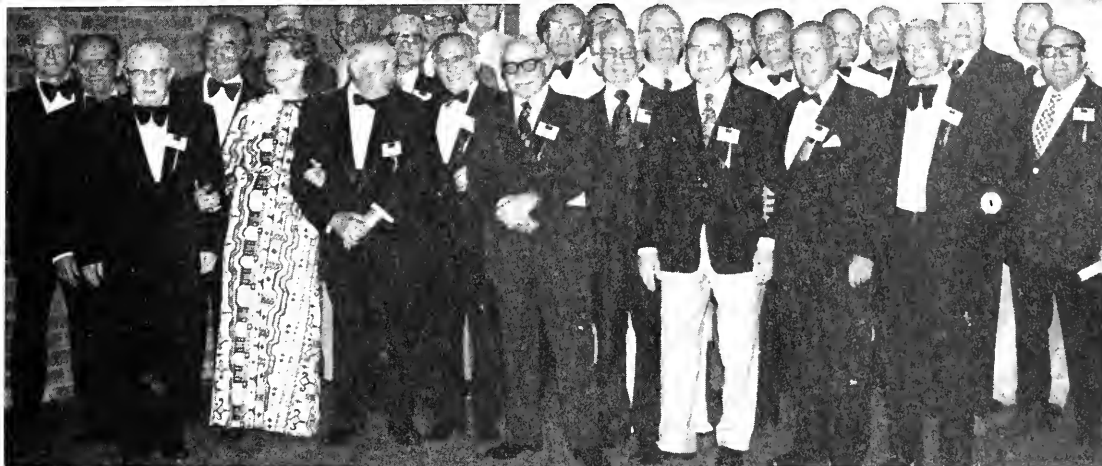
18. Dr. James Roberts, '46, addresses alumni at the business meeting.



19. Dr. John M. Dennis, '45, Dean, University of Maryland School of Medicine; Mr. William M. Davidge, great, great grandson of Dr. John B. Davidge, unveiling plaque; members of Davidge family.



20. Dr. & Mrs. Edward Hazelhurst and children, Davidge family



21. Fifty-year graduates, Class of 1927.



22. Dr. Morton I. Rapoport, '60; Mrs. Rapoport; Russell Wright, '79, volunteer student guide.



23. Dr. Benjamin M. Stein, '35, Mrs. Stein, Dr. Theodore E. Woodward, '38, Dr. Celeste L. Woodward, '38.

## BANQUET



24. Clockwise from left—Board of Regents table: Dr. and Mrs. B. Herbert Brown, Dr. Samuel H. Hoover, Dr. John A. Wagner '38, Barry M. Goldman and friend, Mrs. A. Paul Moss, Gary Miles and fiancée.



25. L-R: Richard D'Antonio, '80, Kathleen D'Antonio, Dr. Joseph D'Antonio, '46, Mrs. Peggy D'Antonio, Robert D'Antonio, Lee D'Antonio, Dr. Leland J. Hanson, '46, Janet Valis, Joseph D'Antonio, '78.



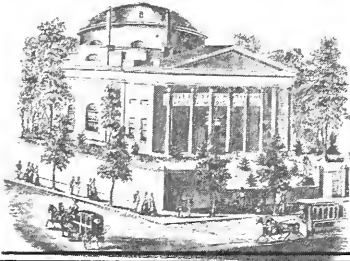
26. L-R: Dr. John Strahan, '49; Dr. Virginia Huffer, '50; Mrs. Singleton; Dr. Robert T. Singleton, '53, President-Elect; Dr. Celeste L. Woodward, '38; Dr. Theodore E. Woodward, '38; Dr. D. Frank Kaltrider, '37.



27. L-R: Dr. David Bacharach, '42, Ellen Volkman, '77, Richard Bacharach, '77; Jeffrey Mosser, '77, Dr. Robert Mosser, '51.

Photographs by: Jim Kurtz, Jack O'Brien, Merrill J. Snyder, Ph.D.

NOTE: If you desire glossy prints of any of the photos in this section, please designate the number(s) of the photo, indicate how many you want and send \$3.00 for each print. Make your check payable to Medical Alumni Association, 522 W. Lombard Street, Baltimore, Maryland 21201.



# DAVIDGE HALL NOTES

Dedicated to the Restoration and  
Preservation of the Nation's Oldest  
Medical School Building

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## DAVIDGE HALL COMMITTEE

John M. Dennis, M.D., '45

John C. Dumler, M.D., '32

William J. R. Dunseath, M.D., '59

John C. Krantz, Jr., Ph.D.

Roger H. Michael, M.D.

James A. Roberts, M.D., '46

John O. Sharrett, M.D., '52

John A. Wagner, M.D., '38

(Chairman)

Theodore E. Woodward, M.D., '38

George H. Yeager, M.D., '29

---

## Davidge Hall Rededicated

As one of the first acts in the restoration and preservation of Davidge Hall, a rededication of this monument to American medicine was held in conjunction with the annual business meeting of the Medical Alumni Association on Thursday, June 2.

As a special part of the annual meeting, the proceedings began with an invocation by (The Reverend) Gibson J. Wells, M.D., former President of the Medical Alumni Association and Ordained Deacon in the Protestant Episcopal Church.

Among the honored guests introduced by Dr. James A. Roberts, President of the Medical Alumni Association, were 30 members of the Davidge family, descendants of Dr. John Beale Davidge, founder and first Dean of the School of Medicine.

A profile of Dr. Davidge was given by Dr. Roger H. Michael, a member of the Davidge Hall Restoration Committee.

Dr. John O. Sharrett, Past President of the Medical Alumni Association and Chairman of the Davidge Hall Committee until 1976, described the progress made in the study of Davidge Hall, its preservation and its declaration by the Department of the Interior as a National Historical Place.

Following the benediction, guests in the audience proceeded to the portico where a bronze plaque was unveiled by Mr. William M. Davidge, great, great grandson of Dr. John Beale Davidge.

## Report of Davidge Hall Committee 1976-77

During the past year, the Davidge Hall Committee has held eight meetings. Attention has been devoted chiefly to the architectural survey and to the establishment of Davidge Hall as an historic monument to American Medicine. It would contain a special kind of museum not only for artifacts of medical science, but also historic documents and memorials for the alumni of those early years, whose ideas and achievements helped lay the foundation for that most prestigious modern science, American

Medicine. We are suddenly aware of this wonderful heritage. It now becomes the duty and pleasure of your Committee to set forth a study plan and program to realize this objective.

In the spring of 1976, the architectural firm of Cochran, Stephenson and Donkervoet along with W. Boulton Kelly, A.I.A. were engaged to undertake a study of the architectural aspects of Davidge Hall, to redraft the working drawings for possible future use, to study the original fabric and such modifications as had been made since construction in 1812. Cost of the survey was assumed from funds contributed by Alumni and friends, proceeds from the sale of pewter plates, a grant from the Maryland Historical Trust and by a grant from the Trustees of the Endowment Fund of the University of Maryland. The report comprises two rather large volumes, photographs and a set of drawings, available for inspection in the office of the Medical Alumni Association upon application. The study began on July 1, 1976 after most of the administrative and teaching activities had ceased. The final report was rendered in April 1977 and has been under consideration since.

Part I of the report concerns the importance of preserving the building in as close to original appearance as possible, largely as a symbol from which new goals can be developed. It is recognized that as a teaching facility, it is obsolete. Certain upgrading is necessary—without altering basic fabric. The building will no longer be an active increment in undergraduate instruction, although some classes are planned for Chemical Hall. There is a minimum amount of space for any large amount of on-going activity. Despite the lack of pleasant surroundings, the building has enough inherent charm to preserve its own heritage, and above all appears to be essentially sound structurally. It is complemented by the ancient English Elm, perhaps older than the building itself. Several important features emerge.

- a. Davidge Hall, by a miracle, exists and is well preserved.
- b. It is a lasting monument to the beginnings of American Medicine; to the nation's 5th oldest

school and is indeed the oldest functioning medical school building in the nation.

- c. As far as is known the unique dome over Anatomical Hall is the oldest in the nation pierced and ringed by skylights—and one of three surviving wooden domed buildings.
- d. The suspension of circular amphitheatres, one over the other, without visible means of support is unique.

The report concluded that fundamentally, Davidge Hall should become a functional museum in itself, allowing for other important functions such as meetings, cultural events, lectures and conventions. Anatomical Hall should be restored to its 1825 appearance, but remain functional within prescribed limits. The report concluded with a recommendation for a large "Davidge Center" recreational area including a high-class restaurant. Detailed recommendations for restoration, painting, etc. concluded Part I.

Part II of the report concerned itself chiefly with an historic approach to the original design and some notion of what was planned for the original structure as well as modification which took place down through the years.

- a. The evolution of the original design seems to have arisen from (1) the Parthenon in Athens, (2) the Pantheon in Rome and (3) the Anatomical theatres in Padua. These concepts were originally conceived by Latrobe or Codefoy (or both) and passed along to Long, the architect-builder who designed and erected the building in 1812.
- b. It was originally designed to have two wings.
- c. It was constructed in two parts—the first part, a square or rectangle and next, the central square—barrel, thus completing the edifice.
- d. Modifications include
  - (1) Closure of a north entrance of Anatomical Hall
  - (2) Closure of first floor hall on west side
  - (3) Skylight over stairs
  - (4) East and west windows in "Alumni Office"
  - (5) Removal of balcony and lowering of ceiling in old "secret" dissecting room, now Alumni Office
  - (6) Closure of northwest stairway
  - (7) The terrazzo hallway
  - (8) Disappearance of outside latrines
  - (9) Disappearance of probable herb garden used to grow medicaments and for teaching
  - (10) Modification of Blue Room
  - (11) Removal of shingles from dome and replacement of same with copper
  - (12) Modification "lantern" and lunettes in

Anatomical Hall for illumination and ventilation.

Actually, aside from replastering and three or four complete changes in lighting, very little has been done to the principal fabric of the building. Steam heat is modern and superficial. There is no central ventilation or air conditioning.

Since receipt of the report, the Committee has addressed itself chiefly to the task of developing three main thrusts, no program being complete at this time. They are as follows:

a. *Museum*

Dr. George Yeager has engaged himself wholeheartedly in this project. Already, faculty portraits are being assembled. They will be repaired, cleaned and properly hung.

Active solicitation of historic documents and artifacts relating to the University of Maryland School of Medicine are being sought.

Suggestions directed to Dr. Yeager concerning the Museum will be welcome.

b. *Promotion*

There are plans to honor the many famous physicians who have studied in Davidge Hall. It is proposed that certain anniversary days be celebrated; that the history of the school be entirely re-studied; that certain social or commemorative events be held in Davidge Hall and that all undergraduate students be acquainted with the important historical background of their school.

c. *Fund Raising*

By direct Alumni appeal

Through foundation grants

Through sale of memorabilia

Through governmental grants

Through corporate support

The Committee welcomes the interest, coopera-

---

FINANCIAL SUMMARY\*

1976-77

Revenue (highlights)	\$44,639.00
Donations	\$ 6,600.00
Interest	
and Dividends	5,855.00
Grants	17,954.00
Sale of Plates	12,320.00
Expenditures	\$57,042.00
(Of which \$41,800 was for survey)	

Balance Sheet  
(April 30, 1977)

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\*Complete report may be obtained in Alumni Office.

tion and assistance of the Faculty Wives Association. The potentialities of these ladies and their great measure of interest and competence should materially assist the Committee in its rather full schedule for the coming year.

John A. Wagner, M.D.  
Chairman

*Due to this special report, the continuation of the list of donors will appear in the next issue.*

**Buy Your Old Seat  
Anatomical Hall Seats  
Offered for Sale to Alumni**

Anatomical Hall has been designated as a museum. All but two of the more than 150 seats have been removed and are now being offered to Alumni of the School of Medicine as souvenirs.

These desks may be ordered through Dr. George H. Yeager, Curator, accompanied by a donation of \$50.00 plus shipping charges.

If the former students' chair number is known, it is possible that the number might be supplied if requested.

All inquiries should be made directly to Dr. George H. Yeager at Davidge Hall, School of Medicine.

**Contribution Acknowledged**

A contribution in the amount of \$121.15 has been recently received through the Department of Anatomy, from the family of Charles Allen, a former medical student at the School of Medicine. The Davidge Hall Restoration Committee acknowledges this gift with profound gratitude.

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## Help for the Alcoholic



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# ALUMNI NEWS

*George M. Baumgardner*, '30, Harpers Ferry, West Virginia, retired from general practice in Rosedale, Baltimore County, Maryland in August, 1976. Dr. Baumgardner retired to a cottage in the West Virginia Mountains at the Shannondale Pleasure Club.

...

*Donald M. Pfeifer*, '69, Milford, Delaware, has joined Dr. Edward F. Quinn, III, '69, in the practice of orthopedic surgery in Milford.

...

*Marvin S. Arons*, '57, New Haven, Connecticut, has been appointed Chief, Section of Plastic Surgery, Hospital of St. Raphael in New Haven. He also was appointed to the Board of Directors, Hospital of St. Raphael Foundation.

...

*Constance Boyer Archambault*, '69, Coventry, Connecticut, gave birth to a son, Mark Worthington, in February. She also has an older son, Matthew Andrew, age 3½. On June 1, 1977, Dr. Archambault will leave her position as a Pathologist (Board certified in Anatomic and Clinical) and Laboratory Director of Rocky Hill Veterans Hospital in Connecticut, a position held since the completion of her Hartford Hospital Internship and Residency. At that time, she will join a Pathology Group at Meriden-Wallingford Hospital with a teaching appointment in pathology at the University of Connecticut School of Medicine.

...

*Stanley E. Schwartz*, '41, Mt. Kisko, New York, recently retired from the U.S. Army Reserve after 21 years' service. Dr. Schwartz was commissioned at graduation in June, 1941. He commanded the 307th General Hospital in New York City for 3 years and, previously, other units. Dr. Schwartz retired in the rank of Colonel in January, 1977 at which time the officers and enlisted men honored him at a formal banquet.

...

*Miles E. Drake*, '44, Vineland, New Jersey, is President-elect of the American Academy of Pediatrics, New Jersey Chapter.

...

*Schuyler C. Kohl*, '40, Brooklyn, New York, has been Acting Chairman of the Department of Obstetrics and Gynecology at the Downstate Medical Center, State University of New York, since July 1, 1976.

...

*Theodore E. Woodward*, '38, Baltimore, Md., Professor and Chairman of the Department of Medicine of the University of Maryland Hospital, served as the third Aaron Feder Professor at the New York Hospital—Cornell Medical Center in honor of Aaron Feder, honor graduate of the Class of 1938 of the University of Maryland School of Medicine. Dr. Feder is a leading clinician in New York City and holds the rank of Clinical Professor of Medicine at Cornell.

The Visiting Professorship was established several years ago by a former patient of Dr. Feder. Previous Visiting Professors have been Dr. Proctor Harvey, Georgetown University School of Medicine and Dr. Charles Joiner, Guys Hospital, London.

...

*John C. Dumler*, '32, Baltimore, Md., was honored for his forty years of service to St. Agnes Hospital at a testimonial retirement dinner on Sunday, May 15, 1977, at the Holiday Inn, Baltimore-Washington International Airport.

The dinner was cosponsored by the St. Agnes Hospital board of trustees and the medical staff.

A long-time resident of Catonsville and recently of Queenstown on the Eastern Shore, Dr. Dumler served as chief of the Department of Gynecology at St. Agnes from 1957 until 1970. He also has been a member of the faculty at the University of Maryland School of Medicine and is presently Assistant Professor of Gynecology.

Dr. Dumler was raised in Baltimore City and is a graduate of Baltimore City College. He received his B.S. in 1928 from the University of Maryland in College Park and his M.D. from the University of Maryland School of Medicine.

His postgraduate medical education included a rotating internship at the University of Maryland Hospital, a residency in obstetrics and medicine at St. Agnes Hospital, followed by a two-year residency in gynecology at University Hospital.

During his medical career Dr. Dumler also served on the medical staffs at Bon Secours, Church Home, Women's, Baltimore City, Veterans, Franklin Square, Anne Arundel and University of Maryland Hospitals.

Dr. Dumler is a Diplomate of the American Board of Obstetrics and Gynecology, a Fellow of the American College of OB/GYN, and a member of the North American Obstetrical and Gynecological Society, the Pan Pacific Surgical Association, the American Medical Association, the American College of Surgeons and a life member of the Southern Medical Association. Locally, he holds membership in the Maryland Medical and Chirurgical Faculty, the Maryland Obstetrical and Gynecological Society, and the Baltimore City Medical Society.

...

# FACULTY NEWS

## New Appointments, Promotions, and Resignations

William K. Reisen, Ph.D., promoted to Assistant Professor in International Medicine, effective July 1, 1977.

Edward L. Perl, M.D., appointed to Clinical Instructor in Pediatrics, effective April 1, 1977.

Andrew G. Smith, Ph.D., appointed to Associate Professor of Medicine in Dermatology, effective July 1, 1977.

Frank A. Hamilton, M.D., appointed to Assistant Professor of Medicine, effective September 1, 1976.

Charles Henderson, M.D., promoted to Assistant Professor of Surgery, effective July 1, 1977.

Dermott P. Byrnes, M.D., promoted to Instructor of Surgery, effective July 1, 1977.

Joseph Shear, M.D., promoted to Assistant Professor of Medicine effective July 1, 1977.

Samuel I. O'Mansky, M.D., promoted to Assistant Professor of Medicine, effective July 1, 1977.

Colin Wood, M.D., appointed to Associate Professor of Medicine in Dermatology, effective July 1, 1977.

Sullins Sullivan, M.D., appointed to Assistant Professor of Surgery, effective March 1, 1977.

Nancy K. Detering, Ph.D., appointed to Instructor of Pediatrics, effective March 1, 1977.

Abenamar Arrillaga, M.D., appointed to Instructor of Surgery, effective March 1, 1977.

William T. Carpenter, M.D., appointed to Professor of Psychiatry and Director of the Maryland Psychiatric Research Center, effective May 1, 1977.

Herbert L. Muncie, M.D., appointed to Assistant Professor of Family Medicine, effective July 1, 1977.

Gail L. Lewis, M.S.N., appointed to Instructor of Psychiatry, effective April 1, 1977.

Noel K. Maclaren, M.D., appointed to Associate Professor of Pediatrics, effective July 1, 1977.

Pinar Ozand, M.D., appointed to Professor of Pediatrics, effective July 1, 1977.

Jessie D. Stahl, M.D., appointed to Instructor of Radiology, effective July 1, 1977.

Joseph E. Bush, Jr., M.D., appointed to Instructor of Radiology, effective July 1, 1977.

Erlinda S. McCrea, M.D., appointed to Instructor of Radiology, effective July 1, 1977.

John D. Adams, M.S., appointed to Associate in Social and Preventive Medicine, effective April 15, 1977.

Alfred Steinschneider, M.D., Ph.D., appointed to Professor of Pediatrics, effective June 1, 1977.

Daniel T. Merlis, M.S.W., appointed to Clinical Instructor of Psychiatry, effective April 1, 1977.

Elijah Saunders, M.D., appointed to Clinical Instructor of Social and Preventive Medicine, effective July 1, 1977.

### Krantz Film Wins Award

Earlier this year, Dr. John C. Krantz's film, "William Withering on Digitalis," took the first prize for a dramatic or theatrical film at the Washington Film Festival at the Kennedy Center of Performing Arts.

## Many Thanks . . .

. . . to Stephen Mosberg, Susan Strahan and Russell Wright (Class of 1979) who assisted in acting as hosts and hostess in the Museum and Anatomical Hall during the reception on Wednesday evening, June 1;

. . . to Paul Dyson and his art students at the Dundalk Regional Vocational Center who prepared the numerous posters and signs . . .

. . . to Jim Kurtz, Mary Anne Lantz, Phil Szczepanski, Jack O'Brien, Dr. Merrill Snyder for the excellent photography coverage;

. . . to all the Physical Plant personnel, including Maintenance, Electrical, and House-keeping . . .

. . . last, but not least, to Sheila McNair, Pat Miller and Ruth Caldwell, without whose help there would be no Alumni Day.

Jean D. Goral  
*Assistant Director*



# HONOR AWARD AND GOLD KEY 1977



Dr. John Z. Bowers, eminent educator, medical historian, administrator and researcher, was presented the University of Maryland Medical Alumni Association's Honor Award and Gold Key at its annual banquet on June 2, 1977.

Born in Baltimore, Dr. Bowers attended Gettysburg College. He graduated from the University of Maryland School of Medicine in 1938 and served his internship and residency at University of Maryland Hospital.

During World War II, Dr. Bowers was in the U.S. Naval Reserve Medical Corps (and was awarded the Purple Heart and Legion of Merit for Combat). He was discharged with the rank of Commander.

From 1947 to 1950, Dr. Bowers was Deputy Director of the Atomic Energy Commission's Biology and Medicine Division and worked in Japan determining the radiation effects of the bombs on the survivors of Hiroshima and Nagasaki. Here he developed an interest in ancient and modern Japanese medicine and authored many papers and books on the subject during the three years he spent as a Visiting Professor at the University of Kyoto.

Dr. Bowers became Dean and Professor of Medical Physics at the University of Utah's College of Medicine in 1950; he also served as a Consultant for the Ford Foundation working with the Navajo Indians and travelled to India to train health personnel.

In 1955, Dr. Bowers was appointed Dean and Professor of Medicine at the University of Wisconsin. Before joining the staff of the Rockefeller Foundation in 1964 and the Josiah Macy, Jr. Foundation a year later, he taught at the University of the Philippines. As President of the Macy Foundation, Dr. Bowers has been responsible for directing new programs of medical education and health in America and abroad.

In addition to his duties as President of the Macy Foundation, he is a Trustee and a Member of the Executive Committee of the Nutrition Foundation, a member of the Board of Associate Editors, *Journal of the History of Medicine and Allied Sciences* and Treasurer of the International Academy of the History of Medicine.

Dr. Bowers has held over 20 professional appointments with local, national and international medical organizations such as the Council on Medical Education and Hospitals, AMA; Advisory Committee for Scientific Publications, U.S.P.H.S.; Consultant, World Health Organization, (WHO), Western Regional Office; Consultant, United Nations Educational, Social and Cultural Organization, (UNESCO) Mission to the University of the West Indies; the Advisory Committee, History of Life Sciences Committee, National Institutes of Health, Department of Health, Education and Welfare and the Medical Alumni Association.

Dr. Bowers is the author of 35 articles and 12 books on various medical topics and medical education in the U.S., China and Japan. Included in these are: *Medical Education in Japan*, *Western Pioneers in Feudal Japan*, *Western Medicine in a Chinese Palace* and his most recent book, *An Introduction to American Medicine*, now in press.

Recipient of honorary degrees from Gettysburg College, the University of Maryland and the Medical College of Pennsylvania, Dr. Bowers is also a Chevalier of the French Legion of Honor. He has been twice elected President of Alpha Omega Alpha.

By awarding Dr. Bowers the Honor Award and Gold Key, the Medical Alumni Association acknowledges his distinguished career and his many contributions to medical education and his fellow man.

# ALUMNI NEWS REPORT

TO THE BULLETIN:

I would like to report the following: \_\_\_\_\_

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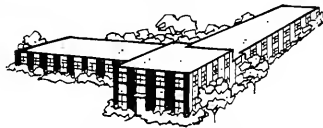
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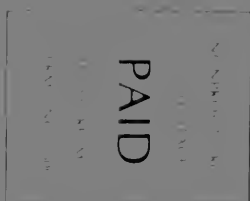
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November, 1977

# BULLETIN

university of maryland school of medicine

UNIVERSITY OF MARYLAND  
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# The prominent individual in need of psychiatric hospitalization . . .

often presents an unusual treatment challenge. Clinical experience suggests that patients with distinctive social or professional backgrounds (including physicians, corporate executives, and government officials) are best treated in a highly individualized and comfortable setting.

Therapeutic progress depends heavily on a specially-trained clinical staff—sensitive to the particular requirements of these prominent individuals.

Hospital programs at Springwood at Leesburg, a 30-bed private psychiatric hospital situated on a 45-acre estate in Loudoun County, Virginia, have been designed to treat this special patient population. The new hospital is located 35 miles west of Washington, D.C.

At Springwood at Leesburg, each patient's treatment program includes:

- individual psychotherapy with the responsible psychiatrist, and
- a carefully planned schedule of adjunctive therapy which takes full advantage of the hospital's quiet, country atmosphere.

Referring physicians are invited to participate in treatment and treatment planning, as appropriate, and always play an important role in discharge planning.

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AT LEESBURG

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The Franklin Square Medical Arts Building was specifically designed for the physician and his patients. The physician is able to function with the greatest efficiency and with the ultimate in convenience.

The patient visiting a physician in the Franklin Square Medical Arts Building, for example, will be provided the maximum health care resulting from the availability within the complex of a *clinical laboratory*, *pharmacy*, *physical therapy services*, and *diagnostic radi-*

*ology services*. These supporting services are further supplemented by the proximity of the hospital itself. The Franklin Square Medical Arts Building is, in fact, located across the street from the acute care hospital and ambulatory service.

Ample visitor and doctor parking has been provided for in this well-landscaped development.

The Franklin Square Medical Arts Building has sound insulating blankets and dense ceiling material to muffle noise. The office space layout flexibility is excellent and we welcome the opportunity to assist you in planning your office for your individual or group practice needs.

The location of the Franklin Square Medical Arts Building provides superior access, near exit 34 on the Baltimore County Beltway. We invite your inquiry.



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Cover Photo: Aerial view of campus looking east toward the Inner Harbor and downtown development. Photo by Philip Szczepanski

# BULLETIN

university of maryland school of medicine

November, 1977

Vol. 62

No. 4

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Published quarterly by the University of Maryland School of Medicine,  
Medical Alumni Association and University of Maryland Hospital.

# The Campus of the Future— Planning for Growth and Change

Richard L. Steiner

In the past 20 years the Baltimore City Campus of the University of Maryland has experienced amazing growth, increasing almost four times in area, and the campus continues to be an organism characterized by growth and change.

The growth or stabilization of undergraduate campuses is directly responsive to trends in the college age segment of the total population. Growth and change in a professional schools campus, such as that in downtown Baltimore, tends to be responsive to growth in the population of the service area, increasing expectations of that population as to levels of service, changing technology and methodology in the professions, and the activity or lack of it in competing institutions.

While the end of rapid growth on this campus appears to be in sight, change will be unending. Some change is gross while other manifestations are more cellular within buildings as new pressing demands are made upon space where previous activities have become obsolete or inefficient. For example, much cellular change is now occurring in the South Hospital built about forty years ago. Extensive and expensive renovation has been programmed in the old building for many years to come, and undoubtedly changes of a cellular nature will continue indefinitely. Such cellular changes occur all of the time on a rather ad hoc basis, but the more gross changes involving new buildings and major renovations can only proceed today through a highly rational, deliberate, planned process which is sometimes so complex and involves so many actors as to raise a question as to whether the objective can be achieved at all.

Planning for the future of the campus is impacted in three major ways:

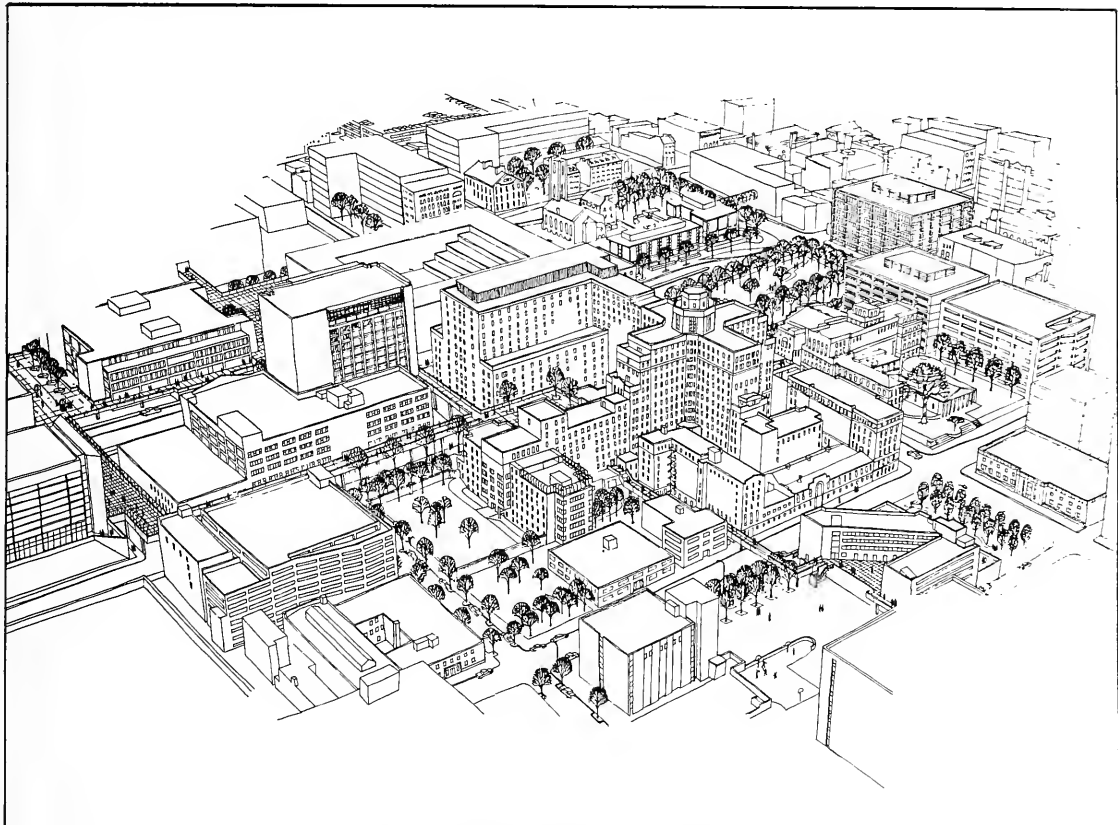
- (a) needs as perceived internally by administrative officers, faculties, deans and the chancellor
- (b) external governmental forces, both administrative and legislative, and
- (c) developments and plans in areas external to the campus, but near enough to have influence upon it.

The internal genesis of planning concepts comes from increasing enrollment, scattered and makeshift facilities, and changing pedagogical methodology. For example, the decision to increase the size of classes entering Medical School from 137 students in 1971 to 200, outmoded facilities, and expansion

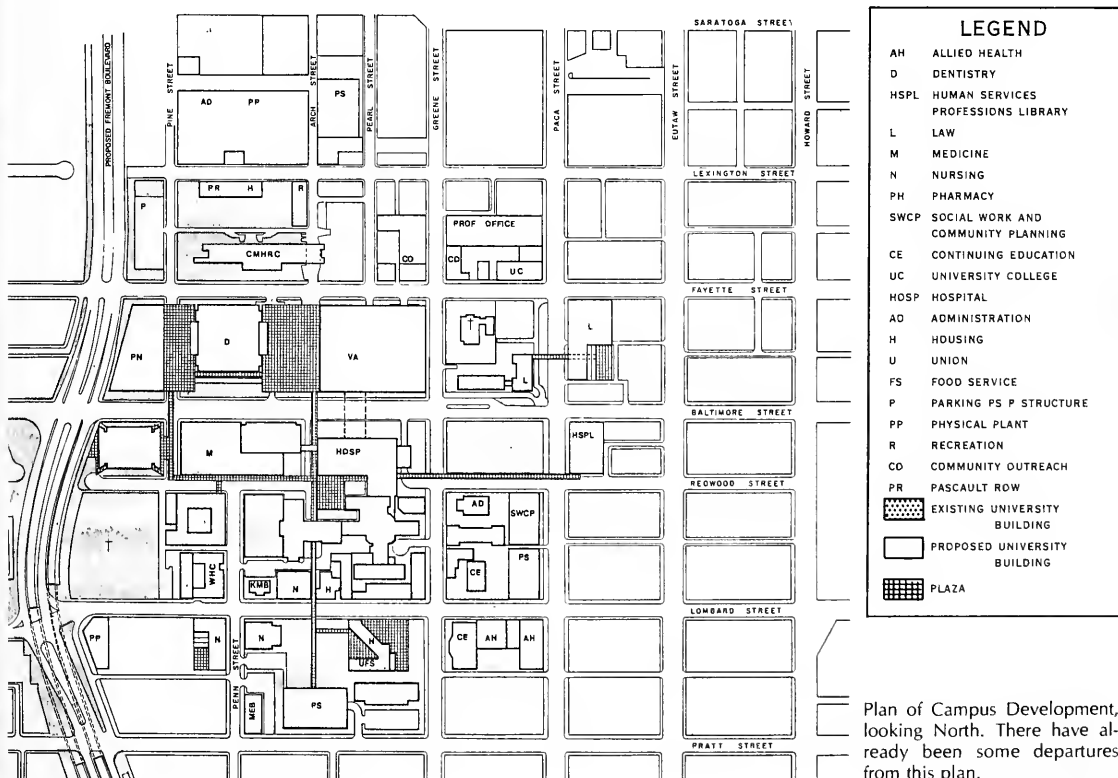
of medical research have necessitated the construction of the nearly completed Medical School Teaching Facility and the new John Eager Howard Hall Tower, while the addition of new programs and a new emphasis on clinical learning experiences in the Law School have necessitated the provision of temporary space in trailers and elsewhere pending a more permanent solution through new construction and renovation.

Not only must any new planning proposals originating on this campus receive the approval of the Central University Administration and the Board of Regents, but they must proceed through a more complicated process involving the Department of State Planning, the State Board for Higher Education, the State Department of General Services, the Governor's Office, and the General Assembly of Maryland before funding can be assured. This whole process has become more formalized in the last several years with standards and guidelines for almost every conceivable type of space on the campus and the necessity of preparing a building program of book size for each proposed building as well as individual statements dealing with environmental impact, racial discrimination, etc. Complexity and timing are such that, as soon as the General Assembly has appropriated funds for capital project activities in the next immediate year, the preparation of requests for the following year must begin.

Twenty years ago, the vicinity of the downtown campus to the west of the central business district was something of a no man's land, for which there were no plans and programs other than those of the University. Today the situation is entirely different, and the campus is surrounded by developments and plans which will restrict the potential for future expansion. To the north, a new office complex for the Social Security Administration is under construction; on the western edge of the campus, the City expects to commence construction of a large new City boulevard in the spring of 1978; to the south, plans have been formulated for widening and parkway treatment of Pratt Street and rehabilitation of the neighborhood known as Ridgely's Delight; to the southeast is the Inner Harbor West Urban Renewal Area where the new Convention Center is under construction; to the east, the City is establishing a special loft district renewal area; to the northeast, elaborate plans have been prepared for revitalizing the downtown retail area, and before long construc-



Artist's conception of proposed UMAB Campus



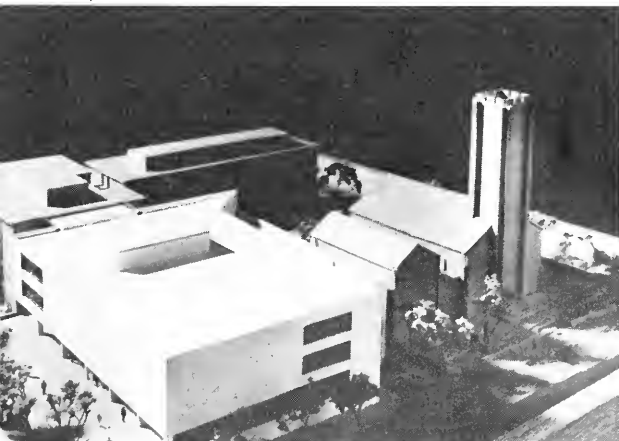
tion will start on a subway station at Eutaw and Lexington Streets. As a consequence of all these developments and plans, the possibilities of adding additional land to the campus are being rapidly foreclosed.

In the last 20 years, several plans for campus development have been prepared, but the most recent is contained in a two-part report, dated February 1975, prepared by the campus planning consulting firm of Richardson, Severns, Scheeler, Greene and Associates, Inc. The preparation of the plan took two years during which there was considerable participation by representatives of the schools, the administration, and City officials. The rather elaborate process involved recording an inventory of campus facilities; establishing goals, objectives, planning assumptions, and planning principles; exploring functional interrelationships; and projecting components of the campus population for ten years. In addition to projecting building needs, the plan deals with such supporting elements as traffic circulation, pedestrian circulation, off-street parking, etc. During all of this activity, it became evident that conceptually the campus is moving slowly from the more narrow concept of health sciences to the broader perspective of human services.

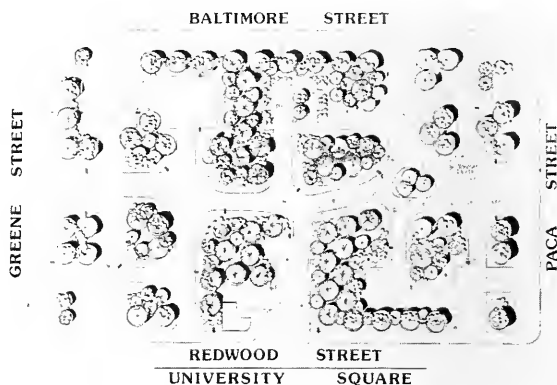
While the extent of past planning is readily evidenced by the numerous new buildings on the campus in recent years, it may be of even greater interest to discuss some of those facilities which, although under design or programmed, are not yet visible to the campus visitor. Under architectural design at the present time are a new library for the Law School, a Hospital Parking Facility and the University Square, and a new School of Pharmacy Building.

The new Law library will be built in the open area north of the present Law School at the southwest corner of Fayette and Paca Streets. When this construction is completed, it is planned to renovate the

Model of proposed new School of Law Library to be built north of present School of Law on vacant land at southwest corner of Fayette and Paca Streets.



space occupied by the present Law library for faculty offices, seminar rooms, and space for student activities. Where the Visitors' Parking Lot now exists as a square block of black asphalt bounded by Baltimore, Paca, Redwood and Greene Streets, construction will start in the near future on three levels of underground parking with a landscaped plaza on top. Not only will this facility increase the parking capacity of this area from 166 to 591 spaces, but an attractive landscaped plaza on top and approximately at street level will become a new focal point and organizing element for the entire campus. Immediately west of the Dental School, between Bal-



Proposed design for University Square—a plaza to be built on top of three underground parking levels in block bounded by Fayette, Paca, Redwood and Greene Streets.

timore and Fayette Streets, will be constructed the new School of Pharmacy to replace Dunning Hall and the makeshift space in several other buildings presently occupied by the School of Pharmacy.

Funds are available also for the architectural design of a new School of Social Work and Community Planning and for a new student housing facility known as Pascault Row; this design work should begin in the near future. The School of Social Work which is now scattered in three or four buildings throughout the campus will be housed in a large new building at the southwest corner of Paca and Redwood Streets—an area which is now a blacktop parking lot.

Pascault Row is an interesting group of eight row houses of generous proportions built in 1819 with such merit in terms of architectural history that they have been placed on the National Register of Historic Places. The University has entered into a contract to buy these houses and adjacent land from the City and restore and renovate them as apartments for 178 students.

Other capital improvement projects scheduled for the next five years include additions to the Schools of Nursing and Dentistry, further renovation of the old University Hospital, a more direct elevated connection between the helistop on top of University Ga-

rage #1 and the Shock Trauma Unit of the Maryland Institute for Emergency Medical Services, and an upper level pedestrian walkway system throughout the campus area for use by the staff, students and patients. Less well formulated but still within the next ten-year period have been programmed additional space for Allied Health activities and Administration and an addition to the Student Union. It is interesting to note that probably the greatest potential for expansion of the student population in the foreseeable future is in the area of paraprofessionals in medicine and dentistry.

Activities which are closely related to the University, but not under its direct control, will undoubtedly have a decisive impact on campus development also. For example, the Baltimore Cancer Research Center has largely moved to the ninth floor of the South and North Hospitals and will expand further into the ninth floor of the new Howard Hall Tower from its previous location in the Wyman Park Public Health Hospital. The idea of a doctors' office building for private practice in the immediate vicinity of the University is one whose time will probably come within the next few years.

By far the biggest impact in the foreseeable future

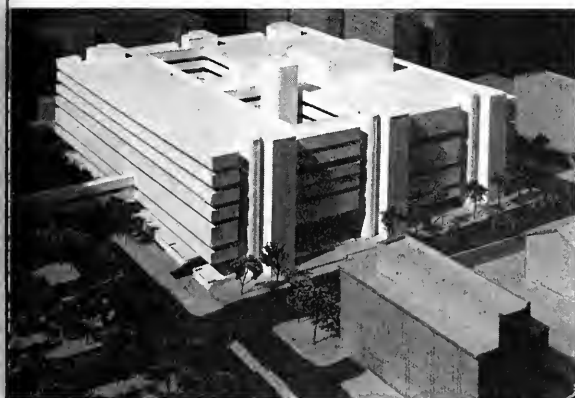
connecting bridge between the Veterans Hospital and the University of Maryland North Hospital across Baltimore Street is planned, and a strong interrelationship between the doctors of the two institutions in consulting, teaching, joint use of equipment and facilities, etc. is anticipated. The new Veterans Administration Hospital also will provide expanded resources for medical residencies, highly desirable with the enlargement of the Medical School classes.

While all this development activity and planning goes on, the University expects to be engaged in a low pressure program of land acquisition around its fringes. Condemnation is not being employed, but the University is acquiring properties from time to time when owners desire to sell them at fair market value.

The last remaining large land acquisition possibility adjacent to the campus is the land of the now defunct E. H. Koester Bakery Company immediately to the north comprising in all 4.2 acres (about 1½ square blocks). The relative long-term needs of the University and the Social Security Administration for this land have been under discussion between the City and the State for some time. It is probable that the University will buy the entire tract and in one corner build a multi-level parking garage to replace the Fayette Street Garage which will be sold to the Veterans Administration. The remainder of the land will be used by the University in the near term for surface parking and other uses and may be sold at a later date for expansion of the Social Security Administration.

In addition to the growth pressures on this campus indicated above, there undoubtedly will be others which cannot now be identified. For example, any new national health program may generate such demands. Research and development activities related to the advancement of medicine may seek to be close to the campus. The opportunities for sponsored research may grow and the movement in medical education toward area health education centers may have repercussions. In conclusion, the many new developments on the campus in the next few years will be indicative of the continuing vitality of campus activities, and undoubtedly growth and change will continue beyond that in unanticipated ways. One of the most interesting observations to faculty, staff, alumni and the general public will be the reversal of the front and back of the campus as a new City boulevard is built to the immediate west and this aspect becomes the most insistent image of the campus in the minds of all.

Ed. Note: Richard L. Steiner is Planning Assistant to the Chancellor at the UMAB campus.



Model of proposed Veterans Hospital with University of Maryland Hospital at left, School of Dentistry upper left, and School of Law at lower right.

will be the development within the campus area of a new Veterans Hospital costing about \$75,000,000. Negotiations are well advanced to transfer to the Veterans Administration the block bounded by Fayette, Greene, and Baltimore Streets and the former bed of Arch Street. This area is now utilized for surface parking and for the University Garage #2 containing 673 spaces. This new hospital is part of a plan of the Veterans Administration to revamp its service program to the Baltimore region which involves changing the functions of the Perry Point and Loch Raven Hospitals and closing Fort Howard Hospital. While 370 beds are planned, a strong emphasis will be placed upon ambulatory services. A

# Carcinoma of the Esophagus— Treatment According to a Philosophy for Palliation

John R. Hankins, M.D. and Joseph S. McLaughlin, M.D.

During the past 7½ years we have developed, on the Thoracic Surgical Service of the University of Maryland Hospital and affiliated hospitals, a definite protocol for the treatment of squamous cell carcinoma of the esophagus. This protocol is based on the philosophy that palliation, particularly the restoration of deglutition, should be the primary objective of treatment, with cure an important, but secondary, goal.

This protocol was adopted because the results with a variety of therapeutic approaches used in a series of 234 patients during the previous 12 years (1958-1969)<sup>1</sup> were unsatisfactory in terms of both palliation and survival. During that period a minority, comprising the most favorable cases, was subjected to an all-out effort at long-term cure consisting of pre-operative radiation therapy followed by resection and restoration of continuity, the latter frequently in two stages. No five year survivals resulted and some either developed esophagorespiratory fistulae or required gastrostomies, or both. Among the larger group who were not considered candidates for the combined radiation-resection protocol, the treatment consisted mostly of radiation therapy. Comparatively few patients were given the benefit of an attempt to resect their tumor. Very few of these patients received any significant palliation. In the entire series of 234 patients, only 6 survived 5 years—3 with lesions in the cervical, upper third and lower third levels respectively who were treated with radiation alone and 3 who underwent a relatively limited resection without irradiation for lower third lesions.

Under the new plan, which was inaugurated in 1969, upper third lesions were treated by irradiation unless contraindicated because of a severe degree of obstruction or tracheal involvement, in which case colon bypass was carried out. When the patient remained in good nutritional condition following colon bypass and the tumor was localized to the mediastinum, total thoracic esophagectomy through a right thoracotomy was carried out three to five weeks after bypass. Even if the tumor was found to be invading local structures, a palliative resection was done and radiation therapy was given post-operatively. Limited (palliative) resection and esophagogastrostomy was performed through a combined right thoracotomy and midline laparotomy approach in patients with middle third carcinomas who had no bronchoscopic evidence of

tracheobronchial invasion, and through a left thoracotomy for lower third lesions. An attempt was made to divide the esophagus 5 cm. above the tumor, and a frozen section was obtained to make certain that the proximal resection margin was tumor-free. Paraesophageal and lesser curvature lymph nodes were removed, but no concerted effort was made to remove more distant areas of potential spread. In the majority of cases residual tumor was left behind. Two rows of interrupted fine silk sutures were used for the anastomosis, the knots of the inner row being tied inside the lumen. A nasogastric tube was guided into the stomach before completion of the anastomosis.

The only patients with middle and lower third lesions who were excluded from palliative resection were those who, because of extreme senility or associated severe medical problems, were prohibitive operative risks and those who were found at bronchoscopy to have tumor invading the tracheobronchial tree. Such patients were treated by insertion of a Mousseau-Barbin or Celestin intra-luminal tube.

If, during resection of middle third carcinomas, deposits of tumor not greater than 2 cm. in diameter were left behind, these areas were marked with metallic clips and postoperative radiation therapy was administered.

Attention to certain details is important in avoiding postoperative deaths or serious complications. By means of intra-arterial, central venous and indwelling urinary catheters, arterial blood pressure, central venous pressure and urine flow were continuously monitored, not only during operation but postoperatively until the patient was stable. This served to obviate fluid overload and periods of hypotension due to inadequate blood and fluid replacement, which might compromise renal function.

Postoperatively we feel it is important to maintain nutrition by parenteral means and to avoid placing stress on the anastomosis before it has had a chance to heal. Intravenous hyperalimentation was started on the third postoperative day. The nasogastric tube was left in place until the seventh postoperative day. At that time a barium swallow was obtained and, if no leak was demonstrated, the nasogastric tube was removed and the patient was cautiously started on oral liquids. After this, hyperalimentation was gradually reduced and eventually discontinued as oral intake was increased.

If the barium swallow on the seventh postopera-

tive day demonstrated an incipient or walled-off anastomotic leak, the nasogastric tube was left in place and intravenous hyperalimentation continued for an additional 7 days. Almost invariably a repeat barium swallow at this time showed closure of the leak.

### Clinical Material and Results:

Since 1969, 65 patients ranging in age from 33 to 76 years have been treated according to the described protocol. Of 19 patients with upper third lesions, 13 were treated primarily by radiation therapy. Of these, 11 completed their course of therapy. These 11 survived for periods ranging from 3.6 to 29.5 months, with a mean survival of 10.1 months. All achieved restoration of deglutition. Six patients deemed unsuitable for radiotherapy, either because of a high degree of obstruction or the likelihood of a radiation-produced esophagorespiratory fistula, were treated by operation. Operation consisted of colon bypass alone in 2 patients, with each surviving 3 months and achieving fair swallowing ability. Three others were treated by colon bypass followed later by resection and survived 2.8, 4.2 and 8.3 months, respectively. In all 3, fairly satisfactory swallowing was restored. The sixth patient underwent a one-stage esophagectomy and colon interposition. She required a pyloroplasty for gastric retention but then went on to survive 3.6 months with fairly satisfactory deglutition during most of this period.

Thirty patients with middle third carcinomas were treated by esophagogastrectomy with esophagogastrostomy. All patients who were explored also had resection. Nine of these patients were treated with tumoricidal radiation therapy early in the postoperative period. Of the 30 patients treated by esophagogastrectomy, 4 died postoperatively (13%). The causes of death were diverse. Two men with cirrhosis, aged 73 and 67, died of hepatic failure. One patient died of shock and respiratory failure on the fifth postoperative day. One, whose tumor had been entered with spillage during resection, died of overwhelming sepsis from a synergistic necrotizing infection of the thoracic and abdominal incisions, with dehiscence of the former.

Two patients survived more than four years: one remains alive at 6½ years and the other died of a primary oat cell carcinoma of the lung at 49 months with no evidence of recurrence of the esophageal carcinoma. The survival in this series of patients can best be expressed by comparison with those at risk. The number surviving at one year after operation (of all patients operated on more than one year ago) was 11 of 27 patients (41%); at two years, 4 of 22 patients (18%); and at five years, 1 of 9 patients (11%).

The number of patients treated with and without early postoperative radiation therapy is too small to permit a statistically valid comparison. It is worthy of note that, while only 9 of the 30 patients received postoperative radiation therapy, 3 of the 4 who survived more than two years and both of those who survived more than four years received such therapy.

The degree of palliation achieved was gratifying. Every surviving patient was able to ingest a normal diet and to swallow satisfactorily almost to the time of death.

Sixteen patients with lower third carcinomas underwent thoracotomy according to the protocol, but 1 tumor was found to be nonresectable because of extensive spread to the diaphragm, celiac axis, and liver. A Mousseau-Barbin tube was inserted in this patient, who survived 1 month with adequate deglutition. The remaining 15 patients were treated by esophagogastrectomy with esophagogastrostomy; early postoperative radiation therapy was administered for residual disease in the mediastinum in 5 of these patients.

There was 1 postoperative death (6.7%) among the 15 patients treated by resection. This was the only patient in the entire series who died primarily from an anastomotic leak.

One patient remains alive and without evidence of disease at 7½ years. Considering survival in terms of those at risk, the number who survived one year or more after operation (of all those operated on more than one year ago) was 7 of 14 patients (50%). The number who survived two years or more was 4 of 12 patients (33%). Three of 11 patients, (27%), were three-year survivors.

Statistically, no valid comparison can be made between the 5 who received early postoperative radiation therapy and the 10 who did not. None of the 3 patients who survived more than three years received irradiation.

The palliation provided these patients was excellent, and the ability to swallow solid food was restored in all.

It is useful to combine the survival data of the 30 patients treated by resection for middle-third lesions with those of the 15 who underwent resection for lower-third neoplasms. The combined operative mortality was 5 of 45 patients, or 11%. Considering all 45 patients, those who lived one year or more totaled 18 among 41 at risk, or 44%. The five-year survival rate was 2 among 14 patients at risk, or 14%.

If one includes with these two groups the 19 patients treated according to the protocol for upper-third lesions and considers all patients, whether dead or alive, the average survival for all 65 patients has reached approximately 12 months. The opera-

tive mortality among all 51 surgically treated patients was 5 patients, or 9.8%.

### Summary

In summary, we feel that the adoption of a plan of treatment of esophageal carcinoma aimed primarily at palliation has resulted in even more patients achieving long term survival than was the case when the primary aim was long-term cure. At the same time far fewer patients are being made miserable by the treatment and far more are able to swallow satisfactorily.

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ED. NOTE: Dr. Hankins is Associate Professor of Surgery, Division of Thoracic & Cardiovascular Surgery, University of Maryland School of Medicine and Dr. McLaughlin is Professor and Head, Division of Thoracic and Cardiovascular Surgery, University of Maryland School of Medicine.

### Faculty Wives Association Tea

The School of Medicine's Faculty Wives Association will hold its annual Christmas Tea on December 4, 1977 from 2 - 4 p.m. at the home of Mrs. John M. Dennis, 803 Huntsman Road, Towson. Female medical students and/or wives of medical students are invited.

The Association, which was founded in 1969 by Mrs. John H. Moxley III, acts as a welcoming body to newcomers at the School of Medicine and provides an opportunity for members to become better acquainted with one another. Membership is open to the wives of men with academic appointments at the School of Medicine and to women faculty members. The members represent an international group whose activities foster the sharing of their varied backgrounds and the exploration of cultural happenings in the Baltimore-Washington area.

For more information, please contact Mrs. John Diaconis 296-9237.

### Advisory Committee Progress

In the interest of furthering closeness among our alumni, the Advisory Committee of the Medical Alumni Association has been notifying out-of-state alumni of the new graduates who are moving to their area for training. The response to this program has been most favorable; the following letter is exemplary of its reception:

July 25, 1977

William J. R. Dunseath, M.D.  
Chairman, Advisory Committee  
Medical Alumni Association  
University of Maryland at Baltimore  
522 West Lombard Street  
Baltimore, Maryland 21201

Dear Dr. Dunseath:

On July 21, 1977, I contacted Dr. Howard Cushner, the University of Maryland graduate who has moved into our area. Dr. Cushner and I had an interesting discussion, and I am sure we will be able to share some mutual interests.

I appreciate very much, and as it turns out, so did Dr. Cushner, your notifying me of this Maryland alumni who moved into our area. He was more than pleased to receive some sort of contact with a co-graduate.

As to what is going on with me, I think it might be of interest for you to know that I am currently President of the American College of Emergency Physicians, Chief of the Emergency Department of Detroit General Hospital, and Chief of the Section of Emergency Medicine at Wayne State University School of Medicine.

Thank you for your letter of July 14, 1977, and I will, personally, look forward to receiving more information about graduates who have come into the Detroit area.

Sincerely,

Ronald L. Krome, M.D., F.A.C.S.  
Chief, Section of Emergency Medicine  
Associate Professor of Surgery

*Looking Ahead . . .*

Mark Your Calendar

**ALUMNI REUNION**

**May 31 and June 1, 1978**

**June 2—Commencement**



# Dean's Message

John M. Dennis, M.D.

The new academic year is a good time to look back and review what has happened over the past year with an eye on improvement in the future.

During the past year we occupied the John Eager Howard Hall Tower Addition, greatly expanding the research and teaching facilities for both the basic science and clinical departments. The Area Health Education Center (AHEC) Program in Cumberland gained the support of the community, and the teaching program there is in the final stages of development and implementation. Dr. Russell Monroe, who served as Acting Chairman, was named Chairman of the Department of Psychiatry, and Dr. Ralph Scott has been named Chairman of the Department of Radiation Therapy, effective January 1, 1978. Search continues for Chairmen of the Departments of Diagnostic Radiology and Social and Preventive Medicine.

We have continued to address the need for primary care physicians through increasing the number of faculty members and residents in both the Family Medicine and Primary Care Programs. In addition, the faculty of the Primary Care Program, through the Office of Coordination of Primary Care Programs, has played a prominent role in the training of nurse practitioners and clinical pharmacists for the Schools of Nursing and Pharmacy.

Paralleling improvement in our education program has been a rapid growth and improvement in our research program. Our funded research has increased from \$16,417,108 in 1975-76 to \$19,631,141 in 1977-78 an increase of 20 per cent.

The entering class size has been maintained at 175 students selected from over 2000 qualified applicants; 875 were Maryland residents. The statistics of the entering class are excellent with a 3.58 grade point average and MCAT scores which average well above 600. Again this year, we accepted into the third-year class Maryland residents as transfer students from foreign medical schools. This year 11 students were transferred.

As Vice Chancellor for Health Affairs, I am responsible for the development of interdisciplinary programs on the Baltimore Campus, and I can report steady progress is being made. For the first time, all of the health-related schools on the campus have a common academic calendar, an effort aimed at increasing interdisciplinary teaching. In each school, the month of January has been reserved for electives and interdisciplinary programs such as alcohol and drug abuse, geriatrics, intimate human behavior, etc.

This academic year we look forward to occupying another new teaching and research building with



170,000 square feet of usable space—the march continues. Planning will proceed on the development of at least two additional Area Health Education Centers, an inner city and a geriatric one. The Center in Cumberland should also be in full operation. The architect and engineering firm for the construction of the new VA hospital has been recently appointed and planning of this facility will occupy a considerable portion of the faculty's time during the coming year.

For the first time in many years, the School was able to emerge unscathed from the Legislature's annual budget cutting. In addition, we were able to establish what I hope will turn out to be a good working relationship with this body which is, as you know, the key to our continued march to excellence.

The Liaison Committee on Medical Education will visit the School of Medicine on November 14-17, 1977, to review our programs and facilities for the seven-year reaccreditation process. This accreditation process has required the faculty to perform a critical self-study during the past few months. This study has been of great benefit to the School. It has enabled us to have a comprehensive look at our strengths and weaknesses and will prove an invaluable aid in planning our future. The study is in last draft and will be submitted very shortly to the Liaison Committee.

Overall, I believe the past year has been a good one, but we are looking forward to an even better one with increased research funding and increased state support during the coming year.

# Toward Tomorrow

Robert G. Smith

Anyone who has read the excellent booklet—*200 Years of Medicine in Baltimore*—or who has read Professor George Callcott's *History of the University of Maryland* realizes full well that the School of Medicine is a major part of one of the nation's great centers of learning. We all have reason to applaud our university. As Dr. Carl Bode, Professor of English, has advised students, "If you treat it well, this university can more readily become one of the great universities of the world. If you treat it well, your degree will mean more."

Prior to accepting the new position of vice president for university development in June 1976, I made my own evaluation of the university, of its standing in higher education and of its potential for future development. Three important factors brought me here. Firstly, all evidence demonstrated that the university is an excellent institution (one measure, for example, is our membership in the Association of American Universities which many of us think of as including only the 50 best universities in the country). Secondly, the university makes an enormous and positive impact within the State of Maryland, across the nation, and indeed makes many significant contributions to our society. Thirdly, the university has a proud past and a vital future—with many strengths including location, quality of faculty and comprehensiveness of its programs. It is on these that we can build.

Developing an even greater university is the challenge we all face. My role, on a university-wide basis, is to assist by finding effective ways of increasing the flow of support from the private sector, strengthening alumni involvement and commitment, and improving our public relation's effort to interpret the university to its many constituents.

In all these efforts, the School of Medicine is critical to our success. Those of us in central administration are very much aware of the accomplishments of the school and the Medical Alumni Association. We also are very much aware of the need for private funds to accelerate the school's quest for excellence.

At the request of the editor of *The Bulletin*, I welcome this opportunity to give you an overview of how we are organized for fund raising, to share our philosophy, and to pledge my full support in assisting fund-raising programs of the School of Medicine. The Chancellor, the deans, and others on the UMAB Campus are familiar with some of the steps being taken to improve our overall fund-raising efforts. Now we want to extend our reach to a wider audi-



Robert G. Smith

ence, including alumni, businessmen and private foundations.

Briefly, our intention is to maintain a very small staff of professional fund raisers in central administration. At the moment that staff includes: Ed Parnell, Director of Major Resources; John Hendricks, Director of Corporate and Foundation Relations; and Richard Hemmings, Director of Annual Giving. These individuals are knowledgeable in their particular areas of responsibility. They function as fund raisers for the total university. They also provide internal consultation to the components of the university interested in seeking outside support.

Rather than expansion of this small central staff (and we will need all the help we can get), our current philosophy is to encourage more constituency-based fund raising. In those situations where there is real potential, we are attempting to identify and train at least one person for each activity or school, an individual who can spend whatever time is necessary and productive to concentrate attention on fund raising. In particular, we are working with each of the campus offices of University Relations to develop additional leadership for fund raising. In this regard, we are extremely pleased that the Medical Alumni Association has appointed James Allen as its Executive Director.

To support these expanded fund-raising efforts, we are continually upgrading our central services: gift processing, record keeping, list maintenance, printing and mailing. I'm happy to report significant progress has been made in these areas. With the spirit of cooperation which now prevails on all campuses, we should avoid unnecessary duplication of these services.

We now have, I think, a clear philosophy, a workable organization, and a highly positive attitude all across the university. Thus we can turn our attention to the development of mechanisms for fund raising, tools and programs that will be helpful to the School of Medicine and others.

The first step is to strengthen the annual giving programs which form the foundation for all other efforts. On the UMAB Campus the School of Dentistry and Law have already established new efforts and the School of Medicine is developing its own program. Others have shown great interest in building their capabilities in this area.

At the peak of the giving pyramid, the University is concentrating on the President's Club for seeking major gift support. This organization already has 54 members who have contributed \$10,000 or more. Continued growth of this group is supported by attractive printed materials to aid in encouraging individuals of vision to make exemplary gifts and to become members.

Two other projects have been launched that should appeal to potential donors to the school and to the university. The first of these is the Pooled Income Fund (life income contract) which provides an opportunity for donors to make substantial gifts while retaining lifetime income. Gifts to the Pooled Income Fund are co-mingled and managed for the university by Union Trust Company. The benefits to donors include: quarterly payments of interest income for life, immediate tax advantages, and reduction of estate taxes and probate expenses. The Medical Alumni Office will be happy to discuss the Pooled Income Fund in greater detail with any interested individual.

Also, we have started a newsletter containing important financial planning information of interest to any individual who wishes to consider making a deferred gift, e.g., bequests, insurance. This newsletter is available without cost or obligation.

Within the School of Medicine and elsewhere in the university some of the priority needs are apparent. There is, for example, a continuing need for more student financial aid. Scholarships, loans, and other forms of student aid are absolutely essential in order to attract the most able students and to guarantee that no deserving student is denied an education for want of financial support.

Another extremely high priority is the establish-

ment of endowed chairs and professorships. These named positions have long been the hallmark of distinction in the nation's major centers of learning. Since ours is a public university, basic salary support for such faculty positions is provided by the State of Maryland, income from endowment is needed to supplement salaries and to provide other support that will be helpful to our most distinguished faculty. Endowed chairs and professorships give the margin of excellence and provide the competitive advantage needed to attract and retain outstanding teachers, scholars, and researchers. At the same time, endowed positions provide a way for the university to recognize major donors whose names will be associated with the university forever.

There are numerous ways of giving and we have a special brochure that outlines these. Copies are available in all campus offices of University Relations or from central Development Office.

I am delighted to be a member of the university team. I look forward to working with Dean Dennis, Mr. Allen and the Medical Alumni Association, the School of Medicine, and with all those at Baltimore who are eager to help attract the kind of private support that will provide the flexibility for building on our proud past and creating a more distinguished future.

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Ed. Note: Mr. Smith is Vice President for University Development, University of Maryland, College Park.

Photo by: Larry Crouse, Division of Photographic Services, University of Maryland, College Park.

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### **Search Committee— Chairmanship of Physiology**

Dr. William D. Blake, Professor and Chairman of the Department of Physiology since 1960, has expressed his desire to step down as Chairman as soon as a successor can be found.

A search committee chaired by Dr. G. Robert Mason, Professor and Chairman of the Department of Surgery, has been appointed to select a new chairman for the Department of Physiology. Suggestions for candidates to be considered would be most welcome.

Dr. Blake is on a sabbatical leave of absence from September, 1977 through January, 1978 during which he will spend the majority of time at the University of Uppsala, Sweden, within Dr. Ulfendahl's department and the remainder of his sabbatical with Dr. Andersson at the Karolinska Institute in Stockholm.

During his absence, Dr. Floyd J. Brinley, Jr., is serving as Acting Chairman of the Department of Physiology.

# Hospital Finance Activities

G. Bruce McFadden

In the early 1970's, the General Assembly became concerned with the trend and direction of the activity levels, expenditures and financial management of the University of Maryland Hospital. With a primary interest in assuring the State's prudent expenditure of public funds, the Legislature directed the Department of Budget and Fiscal Planning to undertake an examination of the University of Maryland Hospital with emphasis to be placed upon management and cost control. To assist in this effort, the Department of Budget and Fiscal Planning contracted with the Medicus Systems Corporation for a comprehensive examination of the Hospital's organization and management structure, manpower and staffing patterns, management information systems, financial management and financial operations.

The Medicus study, and subsequent examinations by the Legislative Auditor as well as the accounting firm of Ernst & Ernst, concluded that there was a need for improved hospital management and that the Hospital must provide for its own financial management and control. The transfer of financial management functions from UMAB's Office of Business Services to the Hospital Director's Office began in January, 1976. Implementation of this transfer has been a complex undertaking of massive proportions. Sophisticated management systems had to be devised and installed to accommodate the Hospital's continuing operations and to lead the way to enhanced financial control and improved monetary results. A single organization had to be structured, and competent personnel recruited to fill the identified positions. These efforts are continuing.

The one aspect of this transfer of financial control which has perhaps received the greatest public notice has been patient accounting which was transferred to the Hospital in May, 1976. It is clear that the resources which had been available to Business Services were inadequate to the tasks of effectively managing patient accounting, particularly with regard to the control of patient billing and accounts receivable. Consequently, the volume of Hospital accounts receivable had climbed to eight figures, and collection efforts were not significantly effective. This situation was complicated further by repeated failures within the Hospital's data gathering and reporting operation which led to numerous and often internally unidentifiable errors in individual patient accounts.

After assuming control of patient accounting, the Hospital's finance staff made an examination of the patients' accounts receivable. It concluded that, as a result of the very large number of outstanding accounts, the relatively long period of time for which many of them had been outstanding, and the large number of patient accounts carrying relatively small dollar balances (reflecting the large volume of outpatient activities), a major collection effort had to be quickly undertaken. The Hospital was required to utilize the services of the Central Collections Unit of the Department of Budget and Fiscal Planning, which provides account collection services to all agencies of State government.

The scope of the accounts receivable problem is indicated by the numbers: to date the Hospital has turned over to the Central Collections Unit more than 219,000 accounts totaling more than \$37,000,000. Central Collections, in turn, has engaged three outside collection agencies to assist in this effort. To date, several million dollars have been collected through their efforts, and as their procedures are refined, this figure should grow.

This collection process has not, however, been without its problems. The aforementioned inability to consistently capture a very large volume of accurate patient financial data resulted in the Hospital and the Central Collections Unit attempting to collect a large number of erroneous patient bills. Because of the need to design and implement in-house Hospital systems and to hire competent staff, the volume of complaints from improperly billed patients grew to a significant size before appropriate steps could be taken to deal with the situation. This led to some unfavorable picture painting in the local news media and to inquiries from several State officials. To deal with this in the near term, internal procedures have been modified and strengthened, and new patient account review standards implemented. These appear to be having the desired effect, as the number of complaints on patient bills of relatively recent origin has been substantially reduced.

The long term solution to patient accounting problems is the implementation of a computer-based patient billing/accounts receivable system which is integrated into a broad-based hospital information system. Such a system is currently under design as a joint effort of virtually all areas of the Hospital and

UMAB's Health Sciences Computer Center. Because of the diverse information needs of the Hospital and the highly regulated environment within which it operates, the acquisition and installation of this information system will be a time-consuming process. However, the present implementation timetable is to have the patient billing/accounts receivable element of the system up and operating on or about July 1, 1979. Initiation of an on-line total hospital information system is targeted for January 1980 or before, if possible.

In the interim, the Hospital will continue to improve its existing methods with the aim of handling patient accounts with the accuracy, courtesy and promptness that consumers have come to expect of public service institutions.

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Ed. Note: Mr. McFadden is Director of University of Maryland Hospital.

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## Seven Steps to CME Success:

### III. Selecting Learning Objectives\*

William F. Jessee, M.D.

This article is the fourth in a series that presents a systematic approach to the development of a personalized plan for continuing medical education (CME). As the variety of available CME offerings expands, and the cost of each continues to rise, such a systematic approach can become extremely valuable to the busy practitioner in terms of both time and money saved.

The seven essential steps to CME success are:

1. Determine your needs
2. Assess your practice
3. Select specific learning objectives
4. Decide how to achieve each objective
5. Inventory available learning resources
6. Decide on priorities and establish a schedule
7. Evaluate your learning achievement

In the last issue of the BULLETIN, we discussed the assessment of your practice and the development of a personalized practice profile. In combination with the needs assessment conducted earlier, this leads to the selection of specific learning objectives for your personal CME plan. Such objectives should be *specific* and *measurable* to the extent possible; this allows you to determine whether your needs have been met through the learning experiences you select by self-evaluation against your own personal objectives.

The most difficult part of learning is defining objectives. It's often easy to figure out deficiencies but not to analyze those needs and express them as precise objectives, "learnable things", practical-sized pieces that set directions for achievable learning. Sometimes explicit objectives can be quickly derived from observed needs. More often, however, careful analysis is required to set clear, measurable, and achievable learning objectives for yourself.

For example, if you recognize that your reading speed and comprehension are inadequate for the amount of reading material you've decided to cover, the mere statement of the problem immediately identifies two clear-cut objectives:

1. To increase your reading speed by at least 150 words per minute
2. To increase your comprehension to 90%.

Further, you can easily measure achievement of these objectives, using "before" and "after" tests of *comprehension* and *speed*.

By contrast, problems in diagnosis and treatment often are considerably more complex. For example, let's assume that through a review of your records you find that you have missed a case or two of pheochromocytoma. You may feel confident that you already know all the necessary physiology, and colleagues may tell you they have the same problem detecting the symptoms. What "learning objective" can be defined in such a situation? Even if you define an operational learning objective, will you have a chance to evaluate that learning achievement soon enough to insure you won't miss the next case?

A systematic approach to defining specific objectives can be very valuable in such situations. Educa-

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\*This article is based on a publication titled, "Your Personal Learning Plan: A Handbook for Physicians", by Leonard S. Stein, published by the Illinois Council on Continuing Medical Education, 360 North Michigan Avenue, Chicago, Illinois 60601.

tors generally agree that learning can be divided into five specific categories<sup>1</sup>:

- a) Problem solving skills—the ability to analyze a problem into its component parts, understand the relation of the parts to one another, identify alternative solutions in terms of the parts, and select the optimal solution (i.e., the answer that deals best with most parts of the problem, at minimal expenditure of time, energy, and/or money).
- b) Diagnostic-operative skills—competence to perform medical procedures including correct identification of symptoms and their meaning and the necessary manipulative skills appropriate to the diagnosis.
- c) Knowledge—possession of facts, concepts, and principles relevant to your practice.
- d) Attitudinal change—a subtle, often complex, need integral to a sense of professional pride as manifested in willingness to objectively evaluate your performance and to improve it as necessary. Put another way, “attitude” might be defined: Are you happy dealing with the medical problems you confront? Frequently, negative attitudes are associated with inability to perform a given task with the full competence required; improvement in problem-solving skill, diagnostic-operative skill, or knowledge will also produce attitudinal change. Consider, however, these two examples: You might become bored, without realizing it, routinely giving preventive inoculations to well babies, and thus become a bit sloppy at this crucial task. At another level, for moral reasons many physicians dislike treating alcoholic patients. In both cases, a change other than increased competence is necessary to improve the quality of patient care.
- e) Understanding of complex relationships—the ability to fit seemingly unrelated facts into a whole not immediately obvious, in a manner that lets you anticipate likely (or possible) outcomes. Consider this example of a family situation: The adolescent son is losing weight; the mother exhibits severe depression for no discernible physiological reason; the father is frequently absent from his job because of alcoholism. Each might be a separate and unrelated clinical problem, but the whole series of problems might reflect the family’s inability to cope with the son’s experimentation with drugs.

Using this classification system, you can now review your list of CME needs developed in the first step of the process<sup>2</sup> and, for each need, develop precise educational objectives. To return to the pheochromocytoma example used earlier, you

might decide that your specific objectives are:

- a) To learn the typical historical and physical findings of pheochromocytoma (a knowledge objective)
- b) To be able to interpret urinary catecholamine determinations (a diagnostic skills objective)
- c) To be able to perform and interpret the phenolamine provocation test (a diagnostic skills objective)

Each of these is achievable and your success in achieving them is measurable. You can then proceed to the next step, deciding how to achieve each objective. The next issue of the BULLETIN will discuss in detail the considerations involved in this important fourth step.

#### References

1. Mager, Robert F., *Preparing Instructional Objectives* (2nd Edition), Belmont, California: Fearson Publishers, Inc., 1975.
2. Jessee, William F., “Seven steps to CME success: I. Determining continuing medical education needs,” *Bulletin of the University of Maryland School of Medicine*, 6(2): 19-20, May, 1977.

ED. NOTE: Dr. Jessee is Assistant Dean for Continuing Medical Education, University of Maryland School of Medicine.

### Future Courses Program of Continuing Education

#### January 1978

##### 13-14

Geriatrics Seminar for the Physical Therapist

##### 19-20

Medical Audit for Office Practice

##### 27-28

Pediatric Cardiology—1978

#### February

##### 8-10

Dermatology Symposium

##### 16-17

Alcohol Symposium

##### 17

Spring Workshop in Clinical Chemistry #1

##### 18-19

Family Medicine Intensive Learning Weekend—OB-GYN

#### March

##### 3 thru April 6

Selected Topics in Family Practice—Part II

##### 3-4

Gastroenterology Symposium

##### 23-25

Cancer Research: Recent Advances

## April

8-9

End-Stage Renal Disease

14

Spring Workshop in Clinical Chemistry #2

15

Blood Diseases Symposium

28-29

Stroke Rehabilitation

## May

6-7

Internal Medicine Review

11-12

Critical Care Symposium

18-19

Continuing Education Workshop

27-28

Neurosurgery Symposium

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# The Maryland Area Health Education Center Program

William S. Spicer, Jr., M.D.

Most practicing health professionals attribute their high level of performance to the excellent quality of their own educational programs. However, whether they are community practitioners or academic health center faculty, they realistically recognize that these educational systems need further changes. Of particular concern has been the perceived gap between the process by which students are educated in medical center environments and the realities of health care delivery as practiced in the community setting.

The past decade has witnessed an acute exacerbation and public recognition of some of the problems to which the artificial separation of the educational and community practice systems has contributed, e.g.

- There are too few primary health care providers and there is a maldistribution of such providers in relationship to geographic population health care needs;
- Health professionals are educated separately and often maintain this separatism throughout their professional careers;
- There are educational deficiencies in their preparation for meeting certain community leadership, organization and planning needs;
- There is a need for improved methods for providing for the continuing education of health professionals; and
- Overall, the direction and control of the health care system is passing into the hands of non-practitioners and the health professional seems unable to influence this change.

In early 1975, the health professional schools of the University of Maryland at Baltimore responded to these needs by conjointly initiating a new program aimed at expanding and relocating many of their educational activities into off-campus, community sites. Concurrently, a new working relationship would be established between faculty and practitioners. This major change in approach to the education of undergraduate and graduate students is known by the acronym of AHEC, which stands for *Area Health Education Center*.

Subsequently, the AHEC Program has become operational, i.e.,

- The University has created an organization to assure coordination of educational and administrative planning and implementation, the *Area Health Education Agency* (AHEA);
- A state law has been passed which provides the mechanism for administrative and fiscal support



Doctors William S. Spicer, Jr., Robert Brodell and Robert Dawson discuss pediatric program at the Children's Medical Group, a component of AHEC at Cumberland.

of the AHEC Program (Sect. 77A§§83-91 Annotated Code of Maryland—Higher Education—"Maryland Statewide Medical Education and Training System");

- The first Center was formally established in Cumberland (July, 1976); and
- The planning of additional centers is underway.

A number of Maryland alumni and other health professionals have expressed interest in the AHEC Program. The purpose of this presentation is to respond to those requests by providing information about the history, philosophy and goals of AHEC, its present status and methodology, and its plans for the future.

## History

In 1970, a Carnegie Commission Report made two major recommendations for medical education: 1) curriculum reform to increase primary care orientation, and 2) organizational reform to develop community-based education via AHECs. In 1971, the Comprehensive Health Manpower Training Act (PL92-157) was enacted. In 1972, there was a national competition for some 60 million dollars of DHEW funding for the development of AHEC programs during the period 1972-77. Ninety-eight medical schools competed and eleven contracts were awarded. The Universities holding AHEC contracts as of 1 October 1972 were: The University of California at San Francisco; The University of Illinois; The University of Minnesota; The University



of Missouri; The University of New Mexico; The University of North Carolina at Chapel Hill; The University of North Dakota; The Medical University of South Carolina; The University of Texas, Medical Branch at Galveston; Tufts University; and West Virginia University.

The development of the North Carolina program has received the most attention. Between 1972 and 1977, the state has provided \$48 million dollars and the federal government \$8 million dollars toward the support of nine AHECs in North Carolina which geographically encompass the entire state.

### **Development of AHEC in Maryland**

The concept for a statewide system of AHECs in Maryland grew from two distinct origins: the State itself, as represented by its health professionals, legislators, health planners, citizen's groups and professional societies, and the University's Health Professions Schools. The State of Maryland has a population of some four million people, over one-half of whom reside in the counties and municipalities forming the Baltimore-Washington corridor. The remaining fraction is spread out over the State in suburban clusters and rural areas. Geographically, the State extends from the Atlantic Ocean on the East to the Appalachians in the West and encompasses topographical and demographical characteristics of striking heterogeneity. Within the borders of the State one can find a representation of all the characteristics of the Nation, good and bad, and Maryland is, therefore, an ideal laboratory for experiments in new approaches to solving the Nation's problems as well as a suitable showcase for the solutions developed.

In terms of its health care services and health professions education programs, Maryland and, in particular, its health professional schools can be viewed in much the same light. The State's problems accurately mirror the Nation's; its educational institutions working with its health practitioners possess the potential to address them.

The State has several areas designated by the Secretary of HEW as medically underserved. These areas are: Garrett County in Western Maryland, Caroline County and parts of Somerset County on the Eastern Shore and a significant number of census tracts within the limits of Baltimore City. In terms of its provider base, the State appears on paper to be adequately and even excessively well-endowed. However, when these figures are corrected by eliminating the State's substantial population of research and armed services personnel, the figures are not as bright and encouraging. Calculating the health care provider and, particularly, physician to population ratio for the State is a difficult task. A more useful measure is the deficits, either perceived

or demonstrable, in the health care delivery system. Taking the latter approach, it is clear that the poor distribution of health resources found nationwide afflict the State as well. Maryland, with its ample physician population, can point to a need of perhaps 1,000 primary care physicians. As noted above, there are also demonstrable areas of service deficits in several of its political jurisdictions. Equally important are the expressions from the people in the State identifying the selfsame needs.

In 1975, the pressure by the people of the State on the legislature to deal with these perceived needs resulted in the reintroduction of legislation that would mandate the dramatic expansion of the State's Medical School and at the same time regionalize its activities. In 1975, the question was how best to accomplish the ends the bill sought.

The University Medical Center took the position that a reshaping of the locations and emphasis of its educational programs offered the best solution. In the interplay between the legislature and the School during the summer and fall, the bill was amended to provide for a system of AHECs located throughout the State, each slightly or dramatically different from the other and designed to actively address the problems of health care education in the State. The AHECs were not to be merely geographical entities but were to incorporate into their design a marriage of local resources and needs to the University's resources and needs. They were to be aimed at population areas found to be underserved either in provider or service characteristics. They were to include all of the professional schools as working partners with local groups, professionals and educational institutions in their development.

House Bill 38 was duly enacted and signed into law in 1976 and the Maryland Statewide Medical Education and Training System (MSMETS) was established.

These activities coincided with previous developments within the University of Maryland at Baltimore which had similar far-reaching effects. The professional schools had begun to develop a series of interdisciplinary primary care programs and some important outreach programs. Coordination of these efforts was required and, to facilitate that, the Dean of the Medical School was appointed Vice Chancellor for Health Affairs. He, in turn, created the Office for Coordination of Primary Care Programs (OCPCP). This group was charged with the specific responsibility to draw together efforts in these areas, develop new ones and give direction to the whole for the Campus and the State. An early decision was to empanel the Area Health Education Agency (AHEA) which was charged with the provision of comprehensive health care educational programs in selected, off-campus communities for under-

graduate, graduate and continuing education. These educational programs are integral parts of the formal curricula of the UMAB for its health professional students in Medicine, Dentistry, Nursing, Pharmacy and Social Work and Community Planning.

The ultimate purpose of this effort is to make comprehensive health care available to all citizens of the State of Maryland and its immediate environs at the best possible cost benefit levels and in a manner that meets the individual needs of each community and is acceptable and equitable to the clients and providers of the community. The mechanism for achieving this purpose is the expansion of the University's teaching programs into community educational sites with the incorporation of practicing health professionals into its faculty.

In order to achieve this purpose the UMAB-AHEA Program has defined several goals which must be met:

- To expand the educational opportunities for health professional students into a variety of geographically separate communities;
- To correct the geographic maldistribution of health professional manpower;
- To achieve the maximal, efficient utilization of physicians, dentists, nurses, pharmacists, social workers and community planners and their supporting paraprofessionals in the interprofessional delivery of comprehensive health care;
- To correct the maldistribution of career choices of health professional graduates so that they will be more congruent with comprehensive health care needs;
- To provide comprehensive educational programs for community practitioners which improve and maintain their professional skills at an optimal level, provide new health care delivery and management methods and, where appropriate, provide and encourage efficient access to career educational ladders;
- To provide a comprehensive health education extension service for the consumers of health care; and, as a result of the above,
- To improve the accessibility, acceptability, quantity, types and quality of health services, working through community resources.

### **The Organization of the Area Health Education Center Program**

The UMAB-AHEA derives its legislative authority from H.B. 38, entitled, "The Maryland Statewide Medical Education and Training System (MSMETS)", enacted by the 1976 legislature. The bill provides for the administration of a system of Area Health Education Centers (AHEC) through the UMAB; their budgetary support as individual and separate components of the UMAB budget; and the establishment

of Advisory Councils for each AHEC, composed of a majority of local providers and lay people, which shall initiate the policy and planning for each center.

The organization of the AHEC program is, at first glance, rather complex. However, if one keeps in mind the basic goals and functions, it becomes a rather logical and effective structure.

In the first place, if the program is really of importance and has a high priority, it must derive its power from the leadership of the academic health center, i.e., those individuals who have principal authority over the development of policy and allocation of resources. Secondly, because its basic purpose is the conduct of primary health care educational programs which are to be carried out on an interprofessional basis, its governance body must include senior representatives of all disciplines who play a major role in primary care education.

A Policy Coordination Board has been constituted which meets these criteria. It is chaired by the Vice-Chancellor for Health Affairs and includes the deans of the five health professional schools, the hospital director, and the chairmen of the departments of medicine, pediatrics, family medicine and social and preventive medicine in the medical school. The chairman of an AHEC Advisory Council automatically becomes a member of this Board. This assures a direct linkage for the local policy and planning body. The Policy Coordination Board deals with a variety of primary care activities in addition to the AHEC program. In terms of AHEC, it has been designated as the Area Health Education Agency.

For efficient operation, the Board delegates the authority for primary care program operation to an executive officer (Director, Office for Coordination of Primary Care Programs) who directs the operation of interprofessional primary care programs through an executive committee (Operations Committee). The Operations Committee consists of those individuals who are responsible for directing and carrying out the day-to-day primary care program activities in each discipline. The Director, OCPCP also serves presently as Director of AHEC but, as the program grows, a separate director will be appointed.

The community AHEC organization is designed to assure independence in basic policy and planning and interdependence in the integration of on and off-campus educational programs. An Advisory Council is established which represents the important disciplines, institutions and agencies. The UMAB Director of AHEC is a member of this body. Otherwise, all members are from the AHEC community.

The Advisory Council is served by a staff, headed by a Center Director. It has at least one standing committee, the Interprofessional Health Education Committee, which is the curriculum planning body.

Its membership is made up of community professionals and UMAB faculty in a ratio of approximately two to one. It will usually appoint subcommittees to carry out specific tasks.

The entire AHEA is governed by a constitution and each AHEC has a set of by-laws which integrate with this constitution but take cognizance of local characteristics.

The first UMAB Area Health Education Center was formally opened in Cumberland in July, 1976 after 18 months of cooperative planning. While we are still in the learning and growth process, the center is functioning well. Those who desire direct information concerning the community point of view could contact the Chairman of the Advisory Council, Dr. W. Guy Fiscus.



Doctors Robert Masten, Morton Rapoport and Robert Brodell in conference.

### The Procedures for the Establishment of an Area Health Education Center

The establishment of a UMAB-AHEC is a complex process in which many criteria must be met:

1. It must be a geographically complete community in terms of the potential for comprehensive health care delivery.
2. It is underserved in terms of meeting its comprehensive health care and/or manpower needs. In Maryland, there are two general categories of such communities, i.e., Rural and Inner-City.
3. There is agreement between representatives of the community and the UMAB-AHEA of the desirability and mutual benefits of creating an AHEC. Ideally, three needs should be met:
  - A. The Community provides primary health care

resources for the education of health professional students;

- B. The community providers desire the presence of these UMAB educational programs to support their own continuing education, administration and planning to direct their own futures; and
- C. The health care consumers desire the presence of these UMAB educational programs and view them as a mechanism for the long-term improvement of their health care services.

While the basic priorities are on interprofessional primary care education, secondary and tertiary care education may be included in selected circumstances. All levels of providers are included to share in the benefits of continuing education programs.

4. The UMAB—Area Health Education Agency (AHEA) always utilizes an interprofessional approach. While the five professions and disciplines within professions do not proceed in "lock step" in terms of program development, planning is done conjointly by all professions through the Policy Coordination Board, the Operations Committee, and the AHEC Advisory Council.
5. An Area Health Education Center (AHEC), upon its formal constitution, becomes a part of the UMAB formal administration and organizational structure. Participation is by invitation with the intention of including all who want to participate. The only requirement is to accept and abide by the decisions of the AHEC Advisory Council which is the locally constituted policy and planning body.
6. The process of an AHEC's planning and development will vary according to the geographic circumstance, provider resources, and unmet population health care needs. For example, in Cumberland there was an initial incorporation of all providers, agencies, institutions and community educational and lay resources. Specific programs were then developed, building first upon local strengths for student educational opportunities and local needs for provider education. New educational programs are then developed to meet specific needs, e.g., health education, geriatrics, etc. This would seem to be an appropriate approach in a rural setting where there is a cultural-political homogeneity of the community. In the inner-city, the cultural-political heterogeneity probably would require the initiation of several nuclei of comprehensive care with later coalition. Specific age-group levels of care (geriatrics or health evaluation, maintenance and counselling) would receive early emphasis as foci for the development of educational programs.

7. It is the intention of the UMAB-AHEA to support and work through local health resources in meeting health care delivery needs. Health services are to be provided by local health providers. AHEA fiscal support is for education, planning and administration. UMAB might initiate selected health care service programs, on a self-supporting basis, where the local AHEC Advisory Council recommends such programs because there are no community resources to meet these service needs and where the Policy Coordination Board approves the allocation of UMAB resources for this purpose.
8. Upon the completion of its planning and development, either a Rural or Inner-City AHEC will provide comprehensive education programs based upon comprehensive health care for 1) all age groups; and 2) all levels of primary health care.

From the above list, we would place particular stress on item number 3. The University of Maryland at Baltimore has no interest, whatsoever, in attempting to force an AHEC program on any group of practitioners, institutions or agencies. Because the past history of cooperative programs between the medical center and communities has often left a credibility gap between the two, there can be no rushing of the discussions necessary to the planning of a new AHEC.

The University believes that there should be four to five such centers eventually. On its part, the University is happy to come to groups which express interest to provide more explicit information, to direct the interested parties to their counterparts in Cumberland, and to enter into meaningful planning of an AHEC.

#### Summary

This brief outline of the UMAB-AHEC program cannot hope to answer all of the detailed and explicit questions which will be raised in the mind of the practicing health professional or community institutions and agencies. Fortunately, there are a number of mechanisms for obtaining answers to these questions. There is an operational AHEC program in Cumberland. There are over 100 health professionals, representing all disciplines, and selected lay people who are actively involved in the program, e.g., over one-third of the members of the Allegany County Medical Society are actively involved in one or another aspect of the Cumberland AHEC. The interested physician can certainly get a satisfactory answer to his questions by visiting or directly contacting these individuals. (UMAB—Cumberland AHEC office—301-777-9150). Nurses, dentists, pharmacists, social workers, college presidents and hospital board members are involved.

Another route is to "eye-ball" the University faculty and staff who are involved. Some fifty members are actively involved in AHEC activities, representing each school.

What do we really think about this program? In the first place the University is committed to the program and we believe that it will become one of the most important aspects of the educational programs of the academic health center.

A practicing dentist in Cumberland, in a burst of enthusiasm, recently said, "AHEC is the last, best hope for health professionals to regain the major role in planning for the future direction of the health care system." While this may be a bit optimistic, it comes very near to touching on the real meaning and potential of AHEC.

No one is insensitive to the high degree of skepticism which such glowing aspirations will generate in the health professional, lay and governmental communities. Only time will tell. For those who are willing to take the risk, the opportunity is present. Over the next two to three years, AHEC will either achieve full operational form or will fail. The University and a large number of health professionals in Cumberland are betting on the former.

Ed. Note: Dr. Spicer is Director of the Office for Coordination of Primary Care Programs, University of Maryland School of Medicine. Photographs by Marianna Herschel.

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# PRESIDENT'S MESSAGE

Herbert J. Levickas, M.D.



Dear Colleague:

In keeping with the precepts of our Association, an organization dedicated to educational, scientific and charitable purposes, your Medical Alumni Association has made a strong commitment to the support of our outstanding medical educational institution. This commitment has been made because of obvious needs in all areas of our school. The economics of our time causing tight Federal and State budgets and diminishing grants and other factors produces a stress with the possibility of compromising the quality of education provided our students and those of allied fields.

The need for support in many areas has been expressed by Dr. John M. Dennis, our Dean. These areas include the maintenance of optimal ratio of faculty to students, increased support of continuing medical education programs, improvement of faculty salaries, provision for equipment, improvement of animal facilities, continuation of necessary and worthwhile research projects and, more importantly, student financial aid.

In a maximum effort to meet our commitment to the School, our Board of Directors, with the assistance of our Executive Director, Mr. James H. Allen; Mrs. Jean D. Goral, Assistant Director; and our staff, will initiate an Annual Fund Campaign to enable you and other interested people and organizations to participate in this project. As progress develops, complete information and details will be related to you through the BULLETIN and additional mailings. Your support in this endeavor will maintain and enhance the stature of our excellent teaching facility.

The planned Annual Fund Campaign is not to be

confused with any other funding activities of the University of Maryland. This activity is to be carried out by your Medical Alumni Association through our office located in Davidge Hall at 522 W. Lombard Street, Baltimore, Maryland 21201. If information is desired in regard to the campaign, do not hesitate to communicate with me or a member of our staff.

Additionally, I would like to explain that the fund raising for the restoration of Davidge Hall will proceed as planned. Your support has provided the continuing impetus for this endeavor, and vital progress has been made under the direction of our Restoration Committee Chairman, Dr. John A. Wagner.

To those of you who continue to be dues-paying members of the Association, the Board of Directors and I would like to express our appreciation of this support. Your dues form the basis for our continuing activities, programs and publications. If you haven't paid your dues, you may do so by sending \$25 to our Davidge Hall address.

Although it is early, I would like to remind you of the dates of our Annual Alumni Reunion. An attractive social and interesting scientific program is being prepared for you by the Chairman of Alumni Day, Dr. Bernard J. Karpers. The dates to circle on your calendar are June 1 and 2, 1978.

Again, I would like to express my appreciation for your past and future support.

# Fund Raising for The Medical School

James H. Allen

You have read about the Medical Alumni Association's new fund raising plans in the articles by Herbert J. Levickas, M.D., Medical Alumni President, and Robert G. Smith, Vice President for Development for the University of Maryland Central Administration. In this article, I will deal with the specifics of the new programs under my direction and the methods by which these programs will be implemented.

As part of the Medical Alumni Association's new directions, the *Medical Alumni Fund Campaign* has been established to encourage medical alumni to lend their financial support to the Medical School on a yearly basis in areas that are insufficiently funded through state and federal funding. The rising costs of education at publicly supported institutions are no less than those of their private counterparts. Public funding is no longer able to fully support state institutions of higher education for many reasons. First and foremost, educational costs have risen faster than the pace at which public revenues have been collected. This is particularly true of professional schools where the operational costs have always been higher. Secondly, in recent years, more public funds have been channeled into private institutions in the form of scholarships, student loans, research and teaching grants and low interest construction loans. If excellence in education is to be maintained and enhanced in the years ahead, it will be necessary for our alumni to support their *alma mater* in the years ahead as their private school colleagues have in the past.

In order that you, as graduates of the Medical School of the University of Maryland, may be a vital part of the school's future excellence, we have established the *Medical Alumni Fund Campaign*. The goal for the first campaign has been modestly set at \$150,000.

There are many areas of the Medical School where support is currently or will soon be needed. Equipment will need ongoing support of \$75,000 per year; the school's animal facilities are in need of an additional \$40,000 per year so that accreditation

may be achieved; the program on continuing medical education is in need of additional yearly support of \$40,000 if it is to fully satisfy the program's aims. These are but three current special projects for which funding is sought. In addition to these, there is an ongoing need for additional financial aid support, library acquisitions and faculty enrichment. Your active participation in the *Medical Alumni Fund* can be a significant contribution in the years ahead.

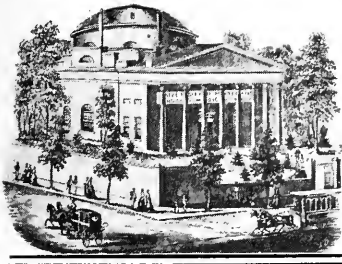
As mentioned in Dr. Levickas' article, the alumni dues of \$25 forms a basis of support for the programs and services of the Medical Alumni Association. Included in these services are the support of the *Bulletin*, administration of reunion programs and a means by which alumni may maintain contact with their classmates and the Medical School. In addition, new services are being developed for alumni who support the dues program. The newest service to be provided is full library privileges at the Health Sciences Library by presentation of a valid Medical Alumni Association membership card. We will continue to advise you of all such new services as they become available to alumni.

The Davidge Hall Restoration Fund will continue as an ongoing capital campaign with an anticipated current goal of \$1,000,000. To date, approximately \$200,000 has been raised towards this goal and many new avenues of support are being explored. Corporate, business, government and private foundation funding is being pursued in addition to the continued support of alumni and friends of Davidge Hall. Many of the reunion classes are undertaking special reunion gift campaigns, the results of which will be announced at the Reunion Dinner Dance on June 2, 1978. One class has already established a goal of \$50,000 with \$15,000 already pledged.

In addition to the three programs described, we would also ask you to consider a planned or deferred gift to the Medical School. A planned gift can take many forms. You may wish to specify the Medical Alumni Association in your Will; or you may wish us to assist you in setting up a trust for the Medical School that will assure an income in the years ahead; or you may just wish to make a onetime large donation for a specific project or department within the School of Medicine. Your gift may be made in a great variety of ways such as securities, insurance, real estate or cash. If you desire additional information or assistance on planned or annual giving to the Medical School, please contact me at the Medical Alumni Association, 522 W. Lombard Street, Baltimore, Maryland 21201.

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Ed. Note: Mr. Allen is Executive Director of the Medical Alumni Association.



# DAVIDGE HALL NOTES

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## Progress Report

Following receipt of the architectural report, activity now centers about an engineering survey of the heating, ventilation, plumbing and electrical wiring of Davidge Hall. Quite properly, all such basics should be surveyed and placed in first-class operating order before a "restoration" of walls, painting, etc. proceeds. Security from fire and theft are also under study. Recently, Mr. Thomas J. Burke, Chief, Baltimore City Fire Department, visited Davidge Hall and personally inspected the structure. Recommendations for fire detection and safety equipment will be made.

## Old Brick Floor Exposed

With the removal of a temporary wooden platform which almost covered the proscenium of Chemical Hall, the old brick floor, essentially intact has appeared. This will be cleaned and restored to its "original" appearance.

## Commemorative Medals Still Available

On the occasion of the sesquicentennial of the School of Medicine in 1957 a commemorative medal was struck by the Medical Alumni Association. A few of these remain. The Board of Directors has authorized the Davidge Hall Restoration Committee to offer these as a token of appreciation for a donation to the Davidge Hall Restoration Fund. There are available six sterling silver medals and thirty-six bronze medals. A silver medal may be obtained for \$500 and a bronze for \$100. Supply is limited. First come—first served.

## Committee Re-Organizes

To more efficiently accomplish the many tasks facing the Davidge Hall Restoration Committee, subcommittees have been designated.

**Museum** headed by Dr. George H. Yeager. The subcommittee will develop and maintain the Davidge Hall Museum.

**Property.** This very important subcommittee, chaired

by Dr. George H. Yeager, will be concerned with the actual development of reconstruction, restoration and refurbishment.

**Fund Raising.** Dr. John C. Krantz, Chairman of this subcommittee, will work with Mr. James H. Allen, Executive Director, to develop a fund raising program applicable to the task of the Davidge Hall restoration.

**Promotion.** Dr. William J. R. Dunseath heads this subcommittee, charged with the development of informational materials designed to present and promote the Davidge Hall restoration. This will include brochures, books, slide presentations, motion pictures and special programs.

**Security.** To properly protect this priceless relic, a thorough study is under way relating to numerous aspects of fire and other security problems.

**Special Events.** It has been proposed that a number of special events, including memorials to distinguished physicians and alumni, commemoration of important dates, and social affairs be planned. Dr. Wagner will head this subcommittee, however Dr. Theodore E. Woodward and the Officers of the Alumni Association, along with Dean Dennis, will also assist in their development.

**Historical.** Dr. John C. Dumler heads this subcommittee, charged with a continuing research program relating to the history and tradition of Davidge Hall and the School.

**Finance.** Dr. George H. Yeager supervises the investing and auditing of the funds dedicated to the Davidge Hall project. Objectives of these investments are liquidity and a reasonable yield. Professional counsel is employed.

## Buy Your Old Seat Anatomical Hall Seats Offered for Sale to Alumni

Anatomical Hall has been designated as a museum. All but two of the more than 150 seats have been removed and are now being offered to Alumni of the School of Medicine as souvenirs.

These desks may be ordered through Dr. George

H. Yeager, Curator, accompanied by a donation of \$50.00 plus shipping charges.

If the former student's chair number is known, it is possible that the number might be supplied if requested.

All inquiries should be made directly to Dr. George H. Yeager at Davidge Hall, School of Medicine.

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# ALUMNI NEWS

*Joshua Seidel*, '37, Kerrville, Texas, has been Chief of the Surgical Service at the Veterans' Administration Hospital in Kerrville for the past 24 years.

...

*Samuel Jackson*, '37, Valley Stream, New York, is Assistant Professor of Clinical Family Medicine, School of Medicine, State University of New York at Stony Brook.

...

*Louis W. Leskin*, '37, Waco, Texas, retired earlier this year. His retirement was preceded by 37 years of civil service including the Civilian Conservation Corps, Veterans' Administration, U.S. Army, and Mental Health and Retardation Community Center. Dr. Leskin's specialty was psychiatry with special interest in institutional psychiatry and community services in social-psychiatry. Dr. Leskin's last contact with classmates of 1937 was in 1942 and 1944 in the military service in Australia when he visited Dr. Pincoff's 42nd General Hospital near Brisbane.

...

*Eugene S. Bereston*, '37, Baltimore, Md., is Professor of Clinical Dermatology at University of Maryland School of Medicine and Chief of Dermatology at Mercy Hospital in Baltimore.

...

*Frank Greenwald*, '37, Treasure Island, Florida, is in the private practice of radiology in Florida.

...

*Grover C. Hedrick, Jr.*, '37, Beckley, West Virginia, is a full-time pediatrician in Beckley.

...

*G. Thomas Abbott*, '37, Towson, Maryland, relocated his home and office to Towson after 37 years of general practice in the Liberty Heights area. Dr. Abbott has delivered over 4,000 babies, many of whom are now bringing their children to him as patients. Dr. Abbott stopped delivering in 1967 but is still one of the rare physicians who makes house calls. One of the interesting features in Dr. Abbott's office is his PRN, a medical news flash radio that gives continuous discussions on various medical subjects. Dr. Abbott is a member of the Baltimore City Medical Society, the Baltimore County Medical Society, the Southern Medical Association, the American Board of Family Practice and the Maryland Academy of Family Physicians.

...

*L. Eugene Daily*, '37, Norwich, New York, ex-President of Eaton Laboratories, is retired and a member of the Board of the Upstate Medical Center, Syracuse, New York. His hobbies include golf, tennis, sailing and swimming.

...

*James Frenkil*, '37, Baltimore, Md., is in private practice in industrial and occupational medicine. Dr. Frenkil is a Fellow in the American Academy of Occupational Medicine and a Fellow in the Industrial Medical Association. He is a member of the Industrial Medical Association, Southern Medical Association, Aviation Medical Association, the American Medical Writers Association and the Maryland Society for Medical Research. A charter Fellow in the American Academy of Family Physicians, Dr. Frenkil is also Chairman, ex-officio, of the Southern Medical Association's Section on Industrial Medicine, Chairman of the Occupational Disease Board of the State of Maryland, and a contributing editor in Industrial Medicine to the *Current Medical Digest*.

Dr. Frenkil is Medical Director of the Mass Transit Administration, and medical advisor to many industrial plants throughout the state. He has presented and published numerous papers on various aspects of industrial and occupational medicine.

His hospital appointments include: Chief, Industrial Medicine and Occupational Diseases, North Charles General Hospital, member of the visiting staffs of Sinai, South Baltimore General, Lutheran, and Fallston Hospitals.

At the 1977 Alumni Reunion, Dr. Frenkil served as Class Captain for the Class of 1937. He informed the BULLETIN staff that their 40th reunion was very successful. Approximately 35 members were in attendance at the festivities reminiscing and renewing old friendships.

...

*D. Frank Kaltreider*, '37, Baltimore, Maryland, practices obstetrics-gynecology in Baltimore. He is Professor of Obstetrics-Gynecology at University of Maryland School of Medicine, Associate Professor of Obstetrics-Gynecology at Johns Hopkins School of Medicine and a consultant at Baltimore City Hospitals.

...

*Jack A. Kapland*, '37, New York, New York, is in private practice in orthopaedic surgery. He is on the faculty of Seton Hall School of Medicine, New Jersey College of Medicine.

...

*Irvin P. Klemkowski*, '37, Baltimore, Maryland, is in private practice in obstetrics-gynecology in Baltimore.

...

Helen E. Llewelyn, '37, Lancaster, South Carolina, is one of the 12 District Directors for South Carolina Department of Health and Environmental Control. She attended the School of Public Health, University of North Carolina, in 1970-71 for her MPH degree. She has two daughters in nursing and one son in medical school.

...

Elton Resnick, '37, Bal Harbour, Florida, is retired from general practice and enjoys fishing in Florida.

...

J. E. Schmidt, '37, Charlestown, Indiana, has been busy over the last ten years with medical and allied lexicography. Some of his works include: *Police Medical Dictionary*; *Dictionary of Medical Slang*; *English Speech for Foreign Physicians, Scientists, Students*; *Paramedical Dictionary*; *Attorney's Dictionary of Medicine*.

...

Albert Shapiro, '37, Baltimore, Maryland, is Professor of Clinical Dermatology at the University of Maryland School of Medicine and is in private practice in dermatology in Baltimore.

...

Morton M. Spielman, '37, New York, New York, has been in general practice in New York City for 38 years. Dr. Spielman retired in July, 1977 and moved to Arizona for service in the U.S. Public Health Corps. He was an attending physician in Medicine at New York University Medical Center Hospital and an associate attending in Medicine at St. Clare's Hospital in New York City.

Dr. Spielman has three sons who are physicians. Stuart Henry, Class of '68, University of Maryland School of Medicine, is a Diplomate of the American Board of Radiology and practices in Hawaii. Louis Victor, Class of '72, Downstate Medical School, is an obstetrician and gynecologist in Alaska with the U.S. Public Health Service. Scott Ronald, Class of '73, Columbia University Medical School, is a Diplomate of Internal Medicine and a Fellow in Cardiology, University of Pennsylvania.

...

John Z. Bowers, '38, New York, N.Y., has been elected a trustee of his alma mater, Gettysburg College. Dr. Bowers is President of the Josiah Macy, Jr. Foundation of New York.

...

Henry Rothkopf, '38, Philadelphia, Pa., has been named Clinical Assistant Professor of Medicine at Temple University School of Medicine.

...

Miriam S. Daly, '50, Albion, Michigan, was recently recertified in Family Practice by the American Board of Family Practice.

...

Leon D. Hankoff, '52, Brooklyn, New York, is senior author of the recently published work, *Jewish Ethnopsychiatry: A Manual for Inservice and House Staff Education*, published by the Federation of Jewish Philanthropies, New York. Dr. Hankoff is Professor of Psychiatry, New York Medical College and Chairman of Psychiatry, Misericordia Hospital Medical Center, Bronx, New York.

...

Leonard B. Glick, '53, Madison, Wisconsin, is Professor and Head of the Department of Social Anthropology of Hampshire College and a visiting lecturer at the University of Massachusetts. Dr. Glick received his Ph.D. in Anthropology from the University of Pennsylvania and was formerly Dean of the School of Social Sciences at Hampshire College, Amherst, Massachusetts.

...

Norman W. Lavy, '55, Westfield, New Jersey, has been elected an Officer and Vice President, Drug Regulatory Affairs, for E. R. Squibb & Sons, Inc., it was announced by Lawrence Marks, M.D., chairman of The Squibb Institute for Medical Research.

Dr. Lavy serves as a liaison between Squibb and the Food and Drug Administration and is responsible for all activities between the company and this federal agency.

After residency training in internal medicine and a post-doctoral research fellowship, he served on the faculties of medical schools of Indiana University, Indianapolis, and Case Western Reserve University, Cleveland, Ohio.

Prior to joining Squibb in 1966 as Director of the Professional Services Department, he was in practice in Cleveland. In 1972, he was appointed Director of the Squibb Drug Regulatory Affairs Department.

Dr. Lavy is a member of the American College of Physicians, American Federation for Clinical Research, American Society for Clinical Pharmacology and Therapeutics, American Society of Human Genetics, Medical Society of New Jersey, and Middlesex County Medical Society.

The author and co-author of several scientific papers, Dr. Lavy is also a Clinical Assistant Professor of Medicine at Rutgers University Medical School.

...

Daniel S. Sax, '59, Brookline, Massachusetts, is Professor of Neurology at Boston University School

of Medicine and Chief of the Neurology Service at the Veterans' Administration Outpatient Clinic in Boston.

...

*Robert A. Fink*, '61, Berkeley, California, has been promoted to Assistant Clinical Professor in the Department of Neurological Surgery, University of California School of Medicine, San Francisco. Dr. Fink is also engaged in the practice of neurological surgery in Berkeley.

...

*Harold A. Burnham*, '66, Glen Cove, New York, has been named Medical Director of the Sterling/Winthrop/Ross International Division of Sterling Drug Inc.

The Sterling/Winthrop/Ross group is Sterling's manufacturing and marketing unit operating in Latin America, southern Europe, Africa, the Middle East and Asia.

Dr. Burnham has served since January of this year as Medical Director of Glenbrook Laboratories, Sterling's principal domestic proprietary medicines division. He joined the company two years ago as Associate Medical Director of Winthrop Laboratories, Sterling's largest domestic pharmaceutical specialties division.

He served for a year as an intern in South Baltimore General Hospital, became a general practice resident at Glen Cove Community Hospital in Glen Cove, N.Y. in 1967 and, two years later, entered private practice in Glen Cove.

Dr. Burnham was certified by the American Board

of Medical Examiners and by the American Board of Family Practice, of which he is a charter member. He currently serves as a clinician for the Nassau County, N.Y. Department of Health and is a member of the American Academy of Family Physicians, the Nassau County Medical Society, the New York State Medical Society, the American Medical Association, the Nassau Physicians Guild, the Pan-American Medical Society and the American Fertility Society.

...

*Kathryn Skitarelic*, '69, Portsmouth, Ohio, became the mother of a baby girl in May, 1977. Dr. Skitarelic is board certified in anatomic and clinical pathology. Her maternal grandfather is Benedict Skitarelic, '41 of Cumberland, Maryland.

...

*Burton Glass*, '71, Freeport, New York, completed his residency in both pediatrics and general surgery and has entered private practice in general surgery in Miami, Florida. Dr. Glass spent the 1976-77 academic year as Administrative Chief Surgical Resident in the Nassau County Medical Center, East Meadow, New York.

...

*Henry Kiang*, '71, Fullerton, California, is in private practice in Family Medicine and is on the staffs at Anaheim General Hospital, West Anaheim Community Hospital, LaPalma Community Hospital and Stanton Community Hospital. He is a member of the Orange County Medical Association and the American Medical Association.

## Class of 1972

Dr. Miriam C. Turner, Class Captain, informed the *BULLETIN* staff that the following individuals attended their Five-Year Reunion in June:

James Biddison  
Cary Brown  
Carolyn Cowles  
Theodore Cryer  
Robert Draper  
Nelson Hendler  
Michael Isikoff  
Sharon Isikoff  
Robert London  
Neil Kappelman

Michael Petriella  
Martin Rosenthal  
Michael Sindler  
Thomas Toner  
Miriam Turner  
Brian Winter  
Barry Wolk  
Celeste Woodward  
Raymond Wright, Jr.

## Austin H. Wood, M.D. 1890-1977

Dr. Austin H. Wood gave no indication of being impressed with me as one of the new interns reporting to the Maryland General Hospital in July, 1941. In fact, he communicated with interns only through their respective residents, except when one of us had violated one of his unwritten rules. Such misdemeanors usually generated somewhat colorful less-than-gentle critiques, tainted with profanity, of our performances.

Aside from these tempestuous moments, Dr. Wood was kind and attentive to his patients. His continuous efforts to maintain proficiency and keep abreast of contemporary knowledge in the field of Urology were exemplary. These qualities had much to do with kindling my own interest in Urology and the beginning of a 35 year friendship with "Pappy" Wood, as he was affectionately known by his residents and associates.

Austin Hislop Wood was born in Willock, Pennsylvania, about 10 miles east of Pittsburgh, on May 26, 1890. His father was one of the first men to work on the open hearth of the Carnegie Steel Company in 1897. In 1902, his family moved to a farm in Huntington County where he attended Saxton High School. Austin prepared to teach in a country school by attending summer Normal School for three sessions. During his three years of teaching, he lived with Dr. B. O. Miller, an 1896 graduate of the Baltimore Medical College. Encouraged by Dr. Miller, Austin arrived at the Madison Street entrance of the Maryland General Hospital to matriculate at the Baltimore Medical College on September 19, 1910. Following the Flexner report of 1912, the Baltimore Medical College merged with the University of Maryland School of Medicine from which Dr. Wood was graduated fourth in his class of 1914. After an internship at the Maryland General Hospital, he entered general practice. While continuing his practice, he was appointed Secretary of the Baltimore City Health Department by Mayor Preston in October, 1915. Two years later, Dr. Wood was commissioned as a First Lieutenant in the United States Army. After attending courses at Roosevelt Hospital (New York), he was assigned to Base Hospital #46 A.E.F. His unit embarked for England and then France, where they arrived in July, 1918. Their first patients were casualties from the battle of Chateau



Portrait of Dr. Wood donated by a grateful patient to the Department of Urology.

Thierry. With the end of World War I, Dr. Wood was ordered back to the U.S.A. in April, 1919 and was discharged from the Army on May 9, 1919.

During the War, Base Hospitals 18 from the Johns Hopkins Hospital and 42 from the University of Maryland Hospital were united with Base Hospital 46 to which Dr. Wood was assigned. Here he became acquainted with Dr. Hugh H. Young, which was the fortuitous beginning of a long and successful career in Urology. In 1920, Dr. Wood began a preceptorship at the Brady Urological Institute of the Johns Hopkins Hospital. While continuing his evening office practice, he spent several days each week in the Urology Clinic and observing in the operating rooms. His colleagues declare that he was not absent from his assigned days in the Clinic for a period of 14 years. He became a devoted protege of Dr. William A. Frontz as well as of Dr. Young.

Dr. Wood became a very busy urologist and was

to become the Chief of Urology at Maryland General, Bon Secours, St. Agnes, and South Baltimore Hospitals. He was granted fellowship in the American College of Surgeons in 1927 and became a Diplomate of the American Board of Urology in 1939. He was a member and seldom missed a meeting of the American Urological Association. His publications, first in 1936, on renal injury still provide a guideline for management. He was appointed to the staff of Brady Urological Institute in 1934.

Dr. Wood usually addressed his interns and residents as "Sonny". On one such occasion, the resident responded with "Okay, Pappy". The nickname endured for the remainder of his days.

"Pappy" was proud of his Scottish ancestry and was a member of the St. Andrews Society. He was a talented amateur photographer and enjoyed showing excellent color movies of his travels, particularly of Scotland.

High among his interests was the University of Maryland School of Medicine. He served two terms as President of the Medical Alumni Association. During his tenure, a committee of the Alumni Association approached the Board of Regents for expansion and increased support of the medical school. Much of this since has been implemented.

At the time of his retirement on November 1, 1966, "Pappy" donated his medical library, including a complete set of bound volumes of the Journal of Urology, to the Division of Urology at the University of Maryland Hospital. One of his grateful patients donated a handsome portrait of Dr. Wood that hangs in the area occupied by the Division of Urology. Dr. Wood is responsible for the Division receiving also some original urological instruments invented and used by one of his medical school classmates, Dr. T. M. Davis. Shortly after his retirement, Dr. Wood bequeathed securities then valued at \$100,000 to become the property of the Division of Urology at a designated future date. These funds are to be used to support urologic research.

"Pappy" became the victim of a cerebrovascular accident on February 25, 1977. His once keen memory never was to return before his death on July 11, 1977. He will be remembered as a devoted friend to many, a formidable adversary to others, a great physician to anyone under his care, and a loyal alumnus of the University of Maryland School of Medicine.

John D. Young, Jr., M.D.



Urological instruments and complete set of bound volumes of the Journal of Urology.



## Obituaries

On December 9, 1976, **Harry Goldsmith**, '13, Baltimore, Maryland. Dr. Goldsmith was Assistant Professor of Psychiatry at the University of Maryland School of Medicine from 1920 to 1940. In 1945, Dr. Goldsmith joined the Veterans Administration and established the first Mental Hygiene Clinic on the eastern seaboard in Baltimore. He was Chief of the Mental Hygiene Service of the Veterans Administration Regional Office until 1967.

On May 6, 1977, **William E. Myles**, '13, White Sulphur Springs, West Virginia. Dr. Myles had been in general practice for over 50 years.

On March 7, 1977, **Abraham C. Leavitt**, '34, Everett, Massachusetts. Dr. Leavitt was in general practice and a staff member at Whidden Memorial Hospital in Everett and at Malden Hospital in Malden.

On April 16, 1977, **James N. Cianos**, '39, Baltimore, Maryland. Dr. Cianos was a surgeon on the staffs at St. Agnes, South Baltimore General and Bon Secours Hospitals.

On April 7, 1977, **Robert Sandler**, '50, Baltimore, Maryland. Dr. Sandler was an ophthalmologist on the staffs of Sinai and Maryland General Hospitals.

On April 18, 1977, **Vincent S. Mikoloski, Jr.**, '55, Worcester, Massachusetts. Dr. Mikoloski took his residency training in urology at the University of Maryland School of Medicine and was in private practice in urology in Worcester.

On April 13, 1977, **Andrew Martin Doyle**, '69, Bronxville, New York. Dr. Doyle served his medical internship at University of Maryland Hospital and specialized in neurology. While working toward his M.D. at Maryland, Dr. Doyle conducted original research that won him the first William Hammond Award for Excellence in Neurology. Dr. Doyle was Assistant Professor of Neurology and Assistant Professor of Neuroscience at Albert Einstein College of Medicine.

On December 15, 1976, **C. Thomas Flotte**, Baltimore, Maryland. Dr. Flotte graduated from Jefferson Medical College in Philadelphia in 1946. He was Professor of Surgery at University of Maryland School of Medicine and Hospital and on the staff of Maryland General Hospital.

On June 5, 1977, **Robert B. Wright**, Frederick, Maryland. Dr. Wright had been Pathologist in Chief at Franklin Square and South Baltimore General Hospitals and retired as Professor of Pathology, University of Maryland School of Medicine. At the time of his death, he was Visiting Professor of Pathology at University of Maryland School of Medicine.

**William L. Byerly**, '11, Hartsville, South Carolina, May 24, 1975

**Austin H. Wood**, '14, Baltimore, Maryland, July 11, 1977

**Elias Freidus**, '22, Miami Florida

**J. Elmer Harp**, '23, Middletown, Maryland, October 9, 1976

**Raphael J. Condry**, '27, Elkins, West Virginia

**Charles A. Walleck**, '29, Westfield, New Jersey, December 10, 1976

**Wilton M. Warman**, '30, Morgantown, West Virginia, December 28, 1976

**John S. Stevens**, '41, Fairfield, Connecticut, February 25, 1977

**Morton Schmukler**, '57, Baltimore, Maryland, August 26, 1977

**Michael N. Coplin**, '65, Short Hills, New Jersey

Note: The above includes all recent deaths of alumni and faculty reported to the Alumni Office or BULLETIN since the annual meeting in June 1977.

# FACULTY NEWS

## New Appointments, Promotions, and Resignations

Otis R. Blaumanis, Ph.D., appointed to Assistant Professor of Neurology, effective September 1, 1976.

John B. Imboden, M.D., appointed to Clinical Associate Professor of Psychiatry, effective January 1, 1977.

Annamaria G. Basili, Ph.D., appointed to Clinical Assistant Professor of Rehabilitation Medicine, effective July 1, 1977.

Jesus M. deMiguel, Ph.D., appointed to Visiting Professor of Social and Preventive Medicine, effective June 1, 1977.

Ronald Geckler, M.D., appointed to Assistant Professor of Medicine, effective July 1, 1977.

Bhupendrakumer M. Patel, M.D., appointed to Clinical Assistant Professor of Psychiatry, effective March 1, 1977.

Martin Chipman, M.D., appointed to Clinical Assistant Professor of Neurology, effective April 1, 1977.

Kenneth L. Harkavy, M.D., appointed to Assistant Professor of Pediatrics, effective July 1, 1977.

Lee A. Goodman, M.D., appointed to Assistant Professor of Radiology, effective July 1, 1977.

Alfred Steinschneider, M.D., Ph.D., appointed to Professor of Psychiatry, effective July 1, 1977.

Martha B. Leffler, M.D., appointed to Clinical Assistant Professor of Ophthalmology, effective July 1, 1977.

Verinder S. Nirankari, M.D., appointed to Assistant Professor of Ophthalmology, effective July 1, 1977.

Vinod Lakhnpal, M.D., promoted to Assistant Professor of Ophthalmology, effective July 1, 1977.

Fereydoon Hadi, M.D., appointed to Instructor of Anesthesiology, effective July 1, 1977.

Abulkulam Shamsudden, M.D., appointed to Instructor of Pathology, effective July 1, 1977.

Elmaslias Menchavez, M.D., appointed to Clinical Instructor of Pediatrics, effective July 1, 1977.

Michael K. Selmanoff, Ph.D., appointed to Assistant Professor of Physiology, effective July 1, 1977.

Lisa J. Mendenhall, B.S., R.T., promoted to Associate in Radiology, effective July 1, 1977.

Stephen M. Deaver, B.S., R.T., promoted to Associate in Radiology, effective July 1, 1977.

Beatriz Arrieta, B.A., R.T., promoted to Instructor of Radiology, effective July 1, 1977.

Walter Schaefer, M.D., promoted to Assistant Professor of Surgery, effective July 1, 1977.

Hubert Leveque, M.D., promoted to Assistant Professor of Surgery, effective July 1, 1977.

Garabed Y. Hadjian, M.D., appointed to Instructor of Anesthesiology, effective July 1, 1977.

Emilio J. Dominguez, M.D., appointed to Clinical Assistant Professor of Psychiatry, effective May 1, 1977.

Arvind K. Pathak, M.D., appointed to Clinical Assistant Professor of Pediatrics, effective July 1, 1977.

Rita P. Ouellet, M.P.H., promoted to Instructor of Social and Preventive Medicine, effective July 1, 1977.

Sue V. Raver, M.D., appointed to Fellow in Pediatrics, effective July 1, 1977.

Barry M. Heatfield, Ph.D., promoted to Assistant Professor of Pathology, effective July 1, 1977.

Thomas J. Kulle, Ph.D., appointed to Assistant Professor of Medicine, effective July 1, 1976.

Douglas Janss, Ph.D., appointed to Associate Professor of Pathology, effective July 1, 1977.

Hans Kaiser, Ph.D., promoted to Assistant Professor of Pathology, effective July 1, 1977.

Sandra L. Loeb, M.D., appointed to Fellow in Pediatrics, effective July 1, 1977.

Zoland Z. Zile, M.S., R.T., promoted to Assistant Professor of Radiology, effective July 1, 1977.

Alberto C. Seiguer, M.D., promoted to Assistant Professor of Pathology, effective July 1, 1977.

Frank E. Parisi, B.A., appointed to Research Programmer in the Dept. of Social and Preventive Medicine, effective June 15, 1977.

Eric S. Solomon, M.A., appointed to Statistical Programmer in the Dept. of Social and Preventive Medicine, effective May 31, 1977.

William A. Valente, M.D., appointed to Instructor of Medicine, effective July 1, 1977.

Wei-Jiung Wu, M.B., appointed to Instructor of Radiology, effective July 1, 1977.

George W. Moran, M.D., appointed to Instructor of Medicine, effective July 1, 1977.

Theodore H. Cryer, M.D., appointed to Clinical Instructor of Ophthalmology, effective July 1, 1977.

Stanley J. Amernick, M.D., appointed to Clinical Instructor of Ophthalmology, effective July 1, 1977.

Judith D. Rubin, M.D., appointed to Assistant Professor of Social and Preventive Medicine, effective July 1, 1977.

Laudelina Lahom, M.D., appointed to Assistant Professor of Obstetrics and Gynecology, effective July 1, 1977.

Frances J. Fitch, M.S., promoted to Assistant Professor of Psychiatry, effective July 1, 1977.

Kate L. Genut, M.S.W., promoted to Assistant Professor of Psychiatry, effective July 1, 1977.

Martin Y. Magram, M.D., appointed to Assistant Professor of Medicine, effective July 1, 1977.

Daniel C. Hardesty, M.D., appointed to Assistant Professor of Medicine, effective July 1, 1977.

David G. Cargo, M.S., appointed to Research Associate in Medicine, effective July 1, 1977.

Dezso K. Merenyi, M.D., appointed to Associate Professor of Pathology, effective July 1, 1977.

James H. Tenney, M.D., appointed to Assistant Professor of Medicine and Pathology, effective July 1, 1977.

Conrad E. Nagle, M.D., appointed to Assistant Professor of Medicine, effective July 1, 1977.

J. Leonard Lichtenfeld, M.D., appointed to Assistant Professor of Medicine, effective July 1, 1977.

Stanley A. Morrison, M.D., appointed to Assistant Professor of Medicine, effective July 1, 1977.

Robert G. Cuming, M.D., appointed to Assistant Professor of Psychiatry, effective July 1, 1977.

William Gray, M.D., appointed to Instructor of Surgery, effective July 1, 1977.

Barbara J. Cephas, M.S.W., promoted to Assistant Professor of Psychiatry, effective July 1, 1977.

Elizabeth L. Rogers, M.D., appointed to Assistant Professor of Medicine, effective July 1, 1977.

Gerald J. Kolaja, Ph.D., appointed to Research Associate in Pathology, effective July 1, 1977.

Peter W. Gage, M.B., Ch.B., Ph.D., appointed to Visiting Research Professor of Pharmacology, effective July 1, 1977.

Willard Graves, Ph.D., appointed to Assistant Professor of Social and Preventive Medicine, effective June 1, 1977.

Barry F. Rudnick, M.D., appointed to Assistant Professor of Psychiatry, effective July 1, 1977.

Joel I. Brenner, M.D., appointed to Assistant Professor of Pediatrics, effective August 1, 1977.

Elliott Badder, M.D., appointed to Assistant Professor of Surgery, effective June 1, 1977.

Kristin Stueber, M.D., appointed to Assistant Professor of Surgery, effective July 1, 1977.

John W. Warren, M.D., appointed to Assistant Professor of Medicine, effective July 1, 1977.

Meyer R. Heyman, M.D., appointed to Assistant Professor of Medicine, effective July 1, 1977.

James Mersey, M.D., appointed to Assistant Professor of Medicine, effective July 1, 1977.

Karen R. Hartman, Ph.D., appointed to Research Associate in Medicine, effective July 1, 1977.

Aden A. Burka, Ph.D., promoted to Assistant Professor of Pediatrics, effective July 1, 1977.

Basil G. Delta, M.D., M.P.H., appointed to Clinical Assistant Professor of Pediatrics, effective July 1, 1977.

Howard A. Wiener, M.D., appointed to Clinical Instructor of Pediatrics, effective July 1, 1977.

Robert R. Harr, M.S., appointed to Instructor of Pathology, effective July 1, 1977.

Lois T. Flaherty, M.D., appointed to Assistant Professor of Psychiatry, effective July 1, 1977.

Meduru Sadasivaiah, M.D., appointed to Instructor of Radiology, effective July 1, 1977.

Alfred D. Hernandez, M.D., appointed to Instructor of Medicine, effective July 1, 1977.

Patricia A. Grady, Ph.D., promoted to Instructor of Neurology, effective July 1, 1977.

Bruce L. Regan, M.D., promoted to Assistant Professor of Psychiatry, effective July 1, 1977.

Sheldon D. Milner, M.D., appointed to Fellow in Medicine, effective July 1, 1977.

Kenneth L. Mummert, M.D., appointed to Assistant Professor of Pathology, effective June 13, 1977.

John L. Hill, M.D., appointed to Clinical Associate Professor of Pediatrics, effective July 1, 1977.

Linda J. Morgan, M.D., appointed to Clinical Instructor of Pediatrics, effective July 1, 1977.

Marc A. Rawitt, M.D., appointed to Clinical Instructor of Pediatrics, effective July 1, 1977.

Judith D. Rubin, M.D., M.P.H., appointed to Clinical Assistant Professor of Pediatrics, effective July 1, 1977.

Karol S. Kosnik, M.D., appointed to Instructor of Family Medicine, effective July 1, 1977.

Biagio Azzarelli, M.D., appointed to Assistant Professor of Pathology, effective July 1, 1977.

Roland J. Boegman, Ph.D., appointed to Visiting Research Associate Professor of Pharmacology, effective July 1, 1977.

Stephen M. Varipatis, D.D.S., appointed to Instructor of Pediatrics, effective June 27, 1977.

Walker L. Robinson, M.D., promoted to Assistant Professor of Surgery, effective July 1, 1977.

Anne C. Redmond, M.D., appointed to Assistant Professor of Psychiatry, effective July 1, 1977.

David L. Camenga, M.D., appointed to Assistant Professor of Neurology, effective July 1, 1977.

Katsukuni Fujimoto, M.D., appointed to Visiting Instructor of Neurology, effective July 1, 1977.

Richard M. Weisman, M.D., appointed to Clinical Instructor of Neurology.

Dean L. Vassar, M.D., appointed to Assistant Professor of Medicine, effective July 1, 1977.

Chi-Shiang Chen, M.D., appointed to Instructor of Medicine, effective July 1, 1977.

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# HISTORICAL PRINTS AVAILABLE

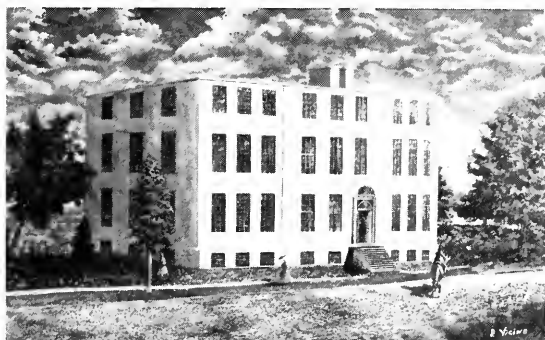
Several years ago two artists were commissioned to paint Davidge Hall and the three "old" hospitals: Baltimore Infirmary, 1823, and the University Hospital of 1870 and 1890.

High quality, signed and numbered reproductions of these original Historical Prints in a limited edition are now available. Arrangements have been made to mail one set of each of the four prints, accompanied by an insert describing the structures and artists, to those contributing \$150.00 to the Davidge Hall Restoration Fund.

**As the edition is limited, your early response is strongly advised.**

John A. Wagner, M.D.  
Chairman  
Davidge Hall Restoration Committee

(Note: individual prints are not available—prints can be sold in sets of four only.)



**Davidge Hall Restoration Fund**  
**Medical Alumni Association**  
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# ALUMNI NEWS REPORT

TO THE BULLETIN:

I would like to report the following: \_\_\_\_\_

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## SUGGESTIONS FOR ITEMS

American Board Certification

Change of Office or Address

Residency Appointment

Research Completed

News of Another Alumnus

Academic Appointment

Interesting Historic

Photographs and Artifacts

Scientific Articles

Name _____
Address _____
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Class _____
Send To: George H. Yeager, M.D. Editor, Alumni Bulletin University of Maryland School of Medicine Room 107 Gray Laboratory Baltimore, Maryland 21201



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